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Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

The Mosquitoes of Louisiana and their Pathogenic Possibilities, with Remarks upon their Extermination.*

By DR. W. H. DUPREE, Baton Rouge, La.

Of this truly cosmopolitan family of diptera, having a geographical distribution extending from the tropics to well within the polar circle; a vertical range of more than 13,000 feet; an antiquity as great as that of the Perbeckian Period; and already numbering in species, whose validity is unquestioned, nearly 400, divided among fifty-eight genera, we have in Louisiana thirty-six species representing the following eleven genera: *Psorophora, Megarhinus, Anopheles, Stegomyia, Janthinosoma, Tæniorhynchus, Uranotænia, Grabhamia, Melanoconion, Aedes,* and *Culex.* Of the genus *Psorophora,* we have two species, viz: *Ciliata* and *Howardii;* of *Megarhinus,* one, *portoricensis;* of *Anopheles,* three, *maculipennis, punctipennis,* and *crucians;* of *Stegomyia,* two, *fasciata* and *sig-*

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* Read before Louisiana Naturalists' Society.

nifer; of *Janthinosoma,* two, *musica* and *varipes;* of *Tæniorhynchus,* one, *perturbans;* of *Uranotænia,* two, *sapharina* and *Lowii;* of *Grabhamia,* three, *sollicitans, jamacensis* and *Spenceri;* of *Melanoconion.* one, *atratus;* of *Aedes,* one, *fuscus,* and of *Culex,* eighteen, *territans, nigritulus, pipiens, restuans, serratus, bimaculatus, confirmatus, cantans, canadensis, reptans, sylvestris, consobrinus, squamger, impiger, tæniorhynchus, discolor* and *Duprei.* From our studies we are inclined to believe that our mosquitoes may be divided into two comprehensive groups: (1), Those whose eggs are provided with a special apparatus for flotation, which so perfectly accomplishes its purpose that they can not be permanently submerged by any manipulation that is consistent with its integrity; (2), those whose eggs are not thus provided, but that are enabled to remain upon the surface of tranquil water by virtue of the air that is entangled in the meshes of a reticulate membrane that envelopes the individual egg or that which adheres to the spines that in some instance proceed from it. In group one we place *Anopheles maculipennis, punctipennis* and *crucians; Culex pipiens, restuans, nigritulus, territans* and *consobrinus; Uranotænia sapharina* and *Lowii; Melanoconion atratus;* and *Tæniorhynchus perturbans* (12). Their eggs, excepting those of the three *Anopheles,* are deposited in boat-shaped masses; all are intolerant of dessication, and as a rule must hatch promptly or perish; hence, in our opinion these species, without exception, perpetuate themselves by hibernating as adults. In one instance we had the eggs of *Anopheles maculipennis* hatch after ten days, drying, in another after remaining upon the surface of water for forty-eight days (Winter).

The eggs of boat shaped masses have invariably refused to hatch after from three to six hours drying on blotting paper. While it is a fact that these boat shaped masses do not sink so long as their water surface maintaining machinery is intact, and also that the eggs do not hatch when the mass is kept submerged by force, it is not true, as stated by Prof. Beyer of Tulane University, "Nor can a single egg be swamped or submerged no matter how much they may be shaken about in the water containing them." On the contrary, when separated they go to the bottom on slight agitation and then promptly hatch. Why the eggs refuse to hatch when submerged in mass and so promptly hatch when apart we do not know.

In group two we include all other species (24) thus far observed. The eggs of these species are laid separately and under conditions not yet understood, resist dessication or submersion indefinitely, because of which we believe these species hibernate in the egg state. We have in our laboratory the eggs of quite a number of species of this second group that were deposited in the summer of 1903, some yet on the water's surface, others at the bottom of the vessel containing them, that are still viable, as can be shown by removing them to a small vessel of water and agitating them. These opinions are expressed with a certain amount of reservation, for we recognize the fact that generalizations from data obtained from observations upon a given species are extremely hazardous when applied to others, often doing great violence to truth; e. g., *Grabhamia Jamacensis* in confinement will bite promptly and frequently, while *Culex territans* under like conditions cannot be induced to bite at all by any amount of coaxing. Col. Giles, from observations made, presumably, upon the larvæ of *Culex fatigans,* states that "larvæ cannot remain under water for any length of time," and that "all species pass the greater part of their time at the surface, lying so that their respiratory opening is open to the air;" yet we have under observation the larvæ of two species, *discolor and Duprei;* that rarely, if ever, come to the surface until they are about to pupate, obtaining the oxygen they require direct from the water, their anal papillæ evidently functioning as gills. Again, speaking of *Anopheles,* he says, "I am inclined to suspect that females are unable to mature and deposit their eggs until they have had a feed of blood." Major Ross states that "it seems that a meal of blood is necessary for fertilization" and adds that "the insects require blood for the propagation of their species." Prof. Beyer says that "blood is not necessary for the fertilization of the female, but for the maturation of her eggs; further experiment," however, he adds, "will be necessary before we can allow the statement to be conclusive."

Having witnessed the laying of fertile eggs by *Anopheles maculipennis, Stegomyia fasciata, Culex pipiens* and *Culex nigritulus,* that were reared in our laboratory and fed solely upon water and dried dates, we are forced to the conclusion that blood is not essential either for the fertilization or the maturation of the eggs of these species, nor, inferentially, those of others. Unquestionably mosquitoes are phytophagous, their bloodthirsty propensity being a secondary acquired habit. It is evident, however, that this sanguinary habit has been transmitted from generation to generation until it has become an irresistible impulse and has acquired almost the force of an organic need. This is especially true of our tpyically domestic species.

There is a general consensus of opinion on the part of observers that *Anopheles* are not dispersed to any great extent or to any considerable distance by the winds, yet Prof. Smith of New Jersey assures us that *Grabhamia sollicitans* permit themselves to be carried by atmospheric currents for more than forty miles.

The larva existence of *Culex territans* or *nigritulus* is more than twice as long as that of *Culex serratus* or *Janthinosoma musica.* Nor is generalization very much safer when applied to the same species of different localities. Theobald tells us that *Anopheles maculipennis* do not bite in England. In Louisiana they bite viciously and are mainly responsible for our malarial fevers. On the authority of Agramonte, *Stegomyia fasciata* in Havana can rarely be coaxed to bite until it is four days old. With us, as a rule, it bites without coaxing within twenty-four hours after emerging from the pupa case. My friend Souchon, of New Orleans, in his paper, "Fruit Vessels, Mosquitoes and Yellow Fever," under the caption "Improbability of Stegomyia on Infected Fruit Vessels Becoming Infected Before Arrival at Quarantine Station," postulates: (1). That the females must be impregnated before they will bite; (2) that the female after one biting does not appear to bite the second time until about five or seven days have elapsed. With us, females isolated in the pupa state and reared apart from males will bite promptly and frequently. Acording to Dr. Johnson, New Jersey, *Anopheles* will not bite for four or five days after becoming imagines. I have just had two *Anopheles maculipennis* gorge upon my blood that are only twelve hours old. There may be more truth in Smith's statement, "that New Jersey mosquitoes are a law unto themselves," than he intended to convey.

Col. Giles, from observations made in India, believes that Celli's statement that "Anopheles will bite every two days or so, and ovulate several times," conveys rather too high an idea of the gastronomic and reproductive capabilities of individual insects. Yet we have recorded as many as nine batches of viable eggs, aggregating more than two thousand deposited by a punctipennis with one fertilization biting every three or four days. As a rule, five or six batches may be obtained from a single female of this species. In fact, a like number of batches may be obtained from nearly all separate egg-laying species. In his account of *Stegomyia fasciata*, which Berkley characterizes as the "first authoritative and complete one published," Agramonte affirms that "the male undoubtedly supports its brief existence upon a Pythagorical diet." With us it is not at all uncommon for the male to live longer than his consort—more than two months, feeding upon dates and even blood when offered upon a swab. This is also true of the male *Culex pipiens, nigritulus* and *territans* and presumably of those of other species. Indeed, the longevity of the mosquito, both male and female, is largely a matter of wholesome food, pure water and an abundance of air.

Under the most favorable conditions of temperature and food supplies, for the development of the *Anopheles maculipennis, punctipennis* and *crucians, Culex territans, nigritulus* and *consobrinus,* pools, puddles, or water areas must persist for fifteen or more days, while for the development of *Janthinosoma musica, Stegomyia fasciata, Culex sylvestris, serratus, confirmatus* and other separate egg laying species, a pool of five days duration will suffice. Indeed a pool of eighty hours when favorably located will permit a generation of some forms, *e. g., Psorophora Howardii* and *Grabhamia sollicitans,* since the egg and pupa stages may be eliminated, for, as a rule, the eggs are already on the ground when the pool occurs, having subsided from the water surface of a previous pool, where they had been deposited, and hatch at once; and the pupa will often deliver the imago in the absence of water.

MOSQUITOES AND MALARIA.

The malaria mosquito theory of Manson, having been removed from its temporary abode in the realm of conjecture by Ross, Grassi and others, now dwells in its permanent home in the region of fact, where it rests in peace and quiet, unmolested save by an occasional attack from some superficial observer. Since the parasites of human malaria require two successive hosts, a mosquito and a human being, to attain sexual maturity and propagation, it is obvious that mosquitoes are their sole transmitters. In the blood of the fever patient they multiply asexually; in the tissues of the mosquito they do so sexually. These parasites are incapable of maintaining the continuity of their species in any other manner, unless they be exceptions (a supposition unwarranted) to that larger group of organisms with which we are familiar, that have an exactly parallel life history and in which this law of parasitism is unvarying. The opinion, however, held by most investigators that the capacity to serve as an intermediary host for these parasites is possessed only by species of a single genus, the *anopheles,* or as Howard puts it, that "there seems to be a co-relation between structural peculiarities and pathological possibilities," is discredited by observations made recently by Theobald of the British Museum, who has erected nine new genera for the accommodation of sixty-five of the seventy-eight species formerly included in the genus (Meigan) *Anopheles,* retaining only thirteen of the original number. Five of the nine new genera furnish intermediaries for the malaria parasites. He finds the greatest diversity in structural characters of the several new genera, as great he states as that between *Mansonia* and *Culex* or *Sabethes* and *Aedes.* Manifestly, then, an accurate determination of the malaria parasite, indeed any parasite, host efficiency of the various species of the different genera of mosquitoes can be made, only by carefully conducted experiments with true specimens of valid species of well established genera, controlled in every instance by parallel experiments similarly conducted with marked examples of species whose capacity to subserve the developmental needs of the sexual stage of the particular species of malaria parasite being investigated is unquestioned.

The following species have been shown to be EFFICIENT HOSTS for the malaria parasites:

Anopheles maculipennis, By Grassi.
Anopheles bifurcatus, By Grassi.
Anopheles nigripes, By Grassi.
Anopheles punctipennis, By Dupree.
Anopheles crucians, By Pothier & Beyer.
Myzomyia Listoni, By James.
Myzomyia funista, By Daniels.
Myzomyia culicifacies, By James.
Myzomyia turkhudi, By James.
Myzomyia Lutzii, By Lutz.
Myzomyia Rossi, By James.
Pyretophorus costalis, By Ross.

Pyretophorus superpictus, By Grassi.
Myzorhynchus sinensis, By James.
Myzorhynchus paludis, By Christophus.
Myzorhynchus barbirostris, By James.
Myssorhynchus fuliginosus, By James.
Myssorhynchus Theobaldi, By James.
Myssorhynchus Stephensi, By James.
Cellia argyrotarsis, By Lutz.
Cellia albipes, By Low.

Twenty-one species, six genera.

The following species have been shown to be INCAPABLE of serving as hosts for the sexual stage of the malaria parasites:

Culex fatigans, By Ross.
Culex penicillaris, By Grassi.
Culex albopunctatus, By Grassi.
Culex pulcretar, By Grassi.
Culex vexans, By Grassi.
Culex rechardii, By Grassi.
Culex pipiens, By Grassi.
Culex nemorosus, By Grassi.
Culex annulatus, By Grassi.
Culex hortensis, By Grassi.
Culex spathipalpis, By Grassi.
Culex elegans, By Grassi.

Culex, stegomyia fasciata, a species of *Aedes* and other blood suckers as *Simulium, Ceratopogon* and *Phlebotomus,* By Grassi.

Eleven species, two genera.

MOSQUITOES AND YELLOW FEVER.

This acute, specific and deadliest of maladies, which has cost our State so enormously in life, in sorrow and in money during its ninety-five visitations since 1693, the date of its first appearance among us, in the light of our newer knowledge of its causation, need no longer be dreaded; for an intelligent application of the measures suggested by this knowledge is fully competent to prevent its recurrence in an endemic or epidemic form, if not acomplish its complete extermination. The results of the brilliant work of Reed and his associates of our Army, in Cuba, are absolutely conclusive of the fact that mosquitoes are the principal, if not sole transmitters of the causa morbi of this disease, and that fomites and filth have no etiological influence whatever, rendering utterly untenable the belief so long and so universally held that the virus of yellow fever is portable in a potentially infective state in fomites, such as clothes, merchandise, bedding, etc., etc. These results, as such, have been accepted by both the French and German Commissioners appointed by their respective Governments to study the question. Although we are still ignorant of the essential nature of the infective principal of yellow fever, we are quite sure that it is not a bacterium to be investigated by bacteriological methods, hence Freire's *Cryptococcus zanthogenicus,* Finley's *Tetragenus febris flava,* Sternberg's *Bacillus X* and Sanarelli's *Bacillus icteroides* have for us only an historical interest. Inasmuch as the malaria parasite may pass the winter in the salivary glands of hibernating anopheles, there is no good reason why the yellow fever germ should not do the same, provided there be for it an efficient hibernating mosquito host.

Stegomyia fasciata, the only species known to be capable of transmitting yellow fever, cannot survive a Louisiana winter; the continuity of the species being maintained solely through egg hibernation.

The bite of insects reared from eggs deposited by yellow fever infected mosquitoes (*Stegomyia fasciata*) is never followed by the disease, hence the virus is not passed to their eggs as occurs with bovine malaria, consequently yellow fever hibernation in Louisiana is an impossibility and will continue to be until an appropriate hibernating species is introduced or our present species adjust their physiological machinery to the rigors of our winters; neither of which is likely to occur. *Signifer,* the only other species of the genus stegomyia inhabiting our State need not be considered in this connection, because of its rarity, its separate egg-laying habit and its peculiar structural characteristics which will eventually cause its removal from this genus. Just how long mosquitoes may retain the infection in a transferable state is unknown. Reed and his associates report an instance of fifty-seven days; Guiteras, another of 101 days. It is probable that they do so during their lifetime. The inability of newly infected mosquitoes to transfer the germ of virus of yellow fever, requiring not less than twelve days after ingesting infected blood to acquire this power, the discrepancy between the incubation period,—three to five days,—of the disease, and the incubation period,—fourteen days and more,—of an epidemic, the existence of the germ or infective principle in the blood at all events in a transferable state, only during the first three or four days of the disease, the inhibiting if not destructive influence of a temperature not higher than 55 degrees F. upon the virus of yellow fever blood, the ready passage of the virus through the pores of a Berkefeld filter, together with the peculiarly restricted geographical distribution of the disease, and other epidemiological features, establish an etiological parallelism between yellow fever and malaria which justifies the inference that the germ, like that of malaria, is of a protozoal nature.

MOSQUITOES AND DENGUE.

The epidemiological facts connected with this specific and highly infectious disease, together with its geographical distribution and symptomotology, suggest for it an etiology similar in nature to that of yellow fever and in consequence thereof its dissemination through a like agency. As a result of recent researches along this line probably prompted by such an idea, Dr. Harris Graham describes an intracorpuscular amœba whose life cycle is longer than that of either of the malaria parasites, showing no pigment at any stage, but in some cases protruding flagella from its periphery which he states he found in the blood of dengue patients in Beyrout, Syria. He also relates that mosquitoes of the genus *Culex* were abundant during its (dengue) prevalence. Furthermore, that the disease occurred in persons under observation, only when they were bitten by infected mosquitoes, and that mosquitoes fed upon the blood of dengue infected persons when transported to dengue free localities were capable of transmitting the disease to healthy persons within five or six days after biting them. While the testimony offered by Dr. Harris is insufficient to establish the guilt of the accused, it is adequate to justify further inquiry as to their connection with the crime.

MOSQUITO DISEASE.

Under the caption "Mosquito Fever," Steiner describes an acute febrile disease which attacks unacclimated subjects in Herzegovinia with the onset of the mosquito season. The patient feels very sick for from six to eight hours, with intense frontal headache, depression, vertigo, thirst and possibly nausea. The thermic movement runs high, often reaching 104 degrees F. and remains high for from one to three days, after which it subsides usually with a crisis. An attack of the disease confers permanent immunity. It can be prevented by protection against mosquito bites, but otherwise it is a much dreaded accompaniment of a stay in the region. Unfortunately the species concerned is not mentioned.

MOSQUITOES AND FILARIASIS.

Our knowledge of this subject began with the discovery by Demarguay in 1863, of an embryo nematode in the milky fluid from a case of chylous dropsy of the tunica veginalis. Three years later the same organism was observed by Mucherer in a number of cases of chyluria. It was Louis, of Calcutta, however, who, in 1872, established the fact that its normal habit is the blood of the human being, and accordingly named it *Filaria sanguinis hominis.* In consequence of the subsequent discovery of other species of blood worms and its nocturnal periodicty, Manson renamed this parisite *Filaria nocturna;* while he designated the remaining six as *F. diurna, F. perstans, F. demasquaii, F. ozzandi, F. megalhæsi,* and *F. gigas.* From the evidence at hand it would seem that only one of the seven described species—*Filaria nocturna*—which is the embryo of *F. Bancrofti,* discovered by Bancroft of Austria in 1876, and named in his honor by Cobbold, possesses any pathologic significance. It is not the small sheathed embryo forms measuring about 1-80 inch in length, which by means of the microscope are seen in peripheral blood that are responsible for morbid manifestations, but the parent worm, three or four inches long, which inhabits the lymphatics; and its immature products of conception. The embryos enter the general circulation as night approaches, gradually increase in numbers until midnight, when they as gradually decrease until morning, returning to the large arteries and lungs. Manson has estimated that at midnight there may be as many as 600 in a single drop of blood; fifty millions circulating simultaneously in the blood current at this time.

The following diseases are known to be produced by this parasite: Abcess, lymphangitis, varicose groin glands, varicose axillary glands, lymph scrotum, cutaneous and deep lymphatic varix, orchitis, chyluria, elephantiasis of the leg, scrotum, vulva, arm, mamma and elsewhere, chylous dropsy of the tunica vaginalis, chylous ascites, chylous diarrhea and probably other forms of disease depending on obstruction or varicosity of the lymphatic or on death of the parent filaria.

Manson, in 1878, having observed the development of filariæ in a certain species of mosquito (*Culex pipiens*) which had fed upon the blood of a filaria afflicted person, conceived the idea that these insects were instrumental in spreading filariasis by acting as an intermediate host for this parasite. He believed that the infected mosquito repaired to some body of water, oviposited and died, and that the parasites liberated from the disentegrated body of the insect, lived in the water, and being received in the stomach of man through drinking, bored their way through the tissues and entered the lymphatics, where they matured, multiplied and finally as embryos reached the general circulation. Bancroft vigorously combated this idea and in lieu thereof offered the suggestion that the parasite is transmitted back to man not through drinking water but by the bite of the mosquito, and in 1890 G. E. Low showed that the metamorphosed worm makes its way to the insect's head, thence to the base of its proboscis, where it remains until the mosquito bites another person, when it leaves the proboscis and enters the wound. The exact nature of the process by which the filaria emerges from the proboscis of the mosquito has not been determined; several speculations have been advanced. It is certain, however, that the route of the infection is quite different from that of the malaria parasite, which is through the hypopharynx along with the salivary secretions.

The final stage of the metamorphosis of filaria in the body of *Culex fatigans,* according to Vincent, is reached between the 16th and 19th day. In *ciliaris vel pipiens* it is attained about the 15th or 16th day.

Its geographical distribution is quite extensive. It has been encountered practically in all tropical and subtropical countries; according to Manson, as far North as Spain in Europe, and Charleston, in the United States of America, and as far South as Brisbane, in Australia.

The following species have been shown to serve as transmitters of filaria:

Culex fatigans, By James.
Culex Microannulatus, By James.
Culex albipictus, By James.

Culex pipiens, By Low.
Culex albimanus, By Vincent.
Anopheles Rossi, By James.
Anopheles nigerrimus, By James.
Cillia argyrotarsis.
Cillia albipes.
Nine species of three genera.

The following have been tested by Bancroft with negative results:
Culex notoscriptus,
Culex annulirostris,
Culex commoverne.
Culex vigilax,
Culex marinus,
Culex nigrothorax,
Culex procox.
Seven species, one genus.

The canine blood worm filaria has been observed by Noe and Grassi to develop in *Anopheles maculipennis.*

MOSQUITOES AND DISTOMIASIS.

Certain facts communicated to Prof. Celli by Dr. F. Martirano while engaged in examining the stomach and salivary glands of hibernating *Anopheles maculipennis* for malaria parasites, suggest that this species—the principal transmitter of malaria—may serve as an intermediate host for distomal diseases also. In said examinations he frequently found in the abdonimal cavity a diminutive trematode, which on close study proved to be a distomum. In May and June, fully half of the insects examined proved to be infected. The trematode was rarely found singly; sometimes as many as ten were found in a single mosquito. Generally they were lodged in the rearmost segment of the abdomen; sometimes in the salivary ducts. At times they were free in the thorax and abdomen. More frequently they were encysted on the outer wall of the stomach and esophagus and on the inner wall of the abdominal cavity. The distomum nearly filled the cyst; was very mobile and endeavored to break through its envelope by butting with its forepart. From these observations of Dr. F. Martirano it is obvious that these parasites may be communicated to man by the bite of an infected mosquito. I venture the assertion that it will yet be shown that *Schistosomum hæmatobum,* the parasite of Bilharzia disease, is disseminated by the mosquito.

MOSQUITO EXTERMINATION.

The student plotting mosquito extermination must be appalled at the magnitude of his task, when he contemplates the facts:

(*a*) That a number of species must have waged a successful warfare against numerous natural enemies under most adverse conditions of environment, at least since the Perbeckian period, from the rocks of which we obtain our first record of their existence.

(*b*) That as adults they may be transported in unlimited quantities to unlimited distances by railway carriages, and water crafts, and in lesser quantities to lesser distances by stage coaches and other means of travel.

(*c*) That some species, to a limited extent, may be dispersed by the wind, while others at times migrate long distances in enormous numbers.

(*d*) That the dormant eggs of some of the separate egg laying species may be carried by the waters of rivers, creeks and lesser streams, and sedimented, viable, all along their course, from their headwaters to their estuaries, wherever there are backwaters, recesses in their banks, or overflows into neighboring ditches.

(*e*) That the adult *nigripes* may utilize the oxygen of the attenuated air of the Himalayas at an altitude of more than 13,000 feet as readily as it does that of the concentrated atmosphere of Scandinavia at sea level.

(*f*) That a pool (no matter its dimensions) of eighty hour's duration may subserve the developmental needs of a *Psorophora,* the giant of the culicidæ.

(*g*) That the larvæ of an *Aedes,* the dwarf of this family of diptera, may sleep the winter through in their icy bed amid the leaves of the pitcher plant.

(*h*) That the larvæ of a *Stegomyia fasciata* may become imagines after forty or more days in practically pure water, subsisting upon no other food than that furnished by the multiplication of the chance organisms that fall from the atmosphere, or despite their very generally accredited fastidious taste, reach the same estate within a period of seven days, in a concentrated solution of fecal matter.

(*i*) That the larvæ of *Culex pipiens* that seem to revel in the filth of the foulest liquids, may find suitable conditions for healthful existence in almost drinkable water, if not altogether pleasing to their incongruous taste.

(*j*) That the larvæ of *Anopheles* may accomplish their relatively long existence in permanent pools and slow flowing streams with grass grown shallows, even though they shelter fishes and predatory insects, escaping destruction by their chromogenic possibilities; some as green as the spirogyra or euglena upon which they feed, others as brown or black as the floating debris to which they cling, having fed upon the adhering pigmented bacteria.

(*k*) That the larvæ of *Culex discolor* and *Duprei* may remain under water during the whole period of their existence, obtaining the oxygen they need direct from the water, their anal papillæ presumably functioning as gills.

(*l*) That the eggs of several species may successfully resist the dryness of a Sahara even when parched by the purple breath of a simoon, survive the wetness of a Cherra Punja where the rain gauge must be graduated to feet; or withstand the fierce heat of a Sibi, where pitch hats are almost essential for human existence.

(*m*) That they may deposit their eggs upon the surface of any water area, large or small, permanent or transient, slow flowing or stagnant, but come to maturity mainly in transient pools, or puddles of no great size or with grass grown borders, because of the absence of or protection from predatory insects and other aquatic enemies. In some instances in pools or puddles when favorably located, in four or five days—the period of larval life—for the eggs already present, hatch as soon as they are water covered, and the pupae resting upon the moist and shaded surface give issue to imagines in the absence of water.

In concluding I desire to read an extract from a paper which I have prepared on the mosquitoes' natural enemies.—Still again, in the city of Baton Rouge, where hydraulic sanitation is ignored; where a piped water service has preceded surface drainage; where almost every hydrant is the source of a chain of puddles in faultily graded gutters; and where cisterns are still largely used for storing *rain* water as potable supplies, *fasciata* of the genus *stegomyia* and *pipiens* of the genus *culex* breed by the millions, that for a part of the summer constitute a veritable pest, the former by day and the latter by night. Fortunately for its inhabitants these breeding places are too transient for the much slower development of anopheles or malarial mosquitoes, and for the same reason, minnows cannot exist in them. But the canals not long since constructed for the city's drainage and that always contain more or less water, being fed largely by the ground water seepage from above their level, teem with minnows that do not allow the existence of mosquito larvæ. If they do, we have been unable to find them. We have considered this phase of the minnow's life habits because we believe that a very practical use can be made of them. In fact the almost complete exemption from malarial infection enjoyed by the more than four hundred cadets and the numerous other occupants of the University buildings, aggregating in number more than thrice that of their former occupants, is mainly due to the mosquito destroying service of these little creatures that in large numbers constantly patrol the shallows of University lake; where formerly existed innumerable pools and puddles, luxuriant vegetation and sheltering trees—the three essentials for the well being of the mosquitoes that there breed in countless numbers and gave to the then army post the reputation of being the unhealthiest in the Southwest. Indeed, the mortality and morbidity were so great that no less than three commissions of inquiry were dispatched from Washington to ascertain their cause. The following report "on the Hygiene of the United States Army, Circular No. 8, Surgeon General's Office, Washington, May, 1875," will give some idea of the then malarious status of this garrison, and with our present knowledge, indicate in a measure, the extent of prevalence of mosquitoes of the genus anopheles. "At Baton Rouge from July, 1870, to June, 1874, inclusive, four fiscal years, there were 1229 cases of malarial fever among the officers and enlisted men that constituted its garrison, the mean strength of which was 171.5, thus giving a ratio per 1000 of cases to mean strength of 1.803 cases." In his work on malaria and malarial disease, Sternberg, Surgeon General U. S. Army, retired list, writes, "That unusual amount of sickness at Baton Rouge is explained as follows: The malarial diseases at the post are immediately due, in great part, to the tract of swamp bordering the northern edge of the reservation, and the continuance of the winds from this quarter is accompanied by a marked increase in the number and gravity of the cases." In confirmation of this statement, we would state that during the latter part of the occupation of this post by the United States troops, and prior to its use by our State cadets, a study of the subject by one of us in connection with that of the Post surgeon, revealed the fact that periodic fever could be produced at will, by leaving open at night the windows fronting this swamp. But how different is the explanation interpreted in the light of our present knowledge of malaria and mosquitoes. Then we confidently believed that by opening these windows we gave a readier entrance to malaria—bad air—a subtle miasma evolved from soil alternately subjected to the action of heat and moisture, and in some mysterious way connected with vegetable decomposition and wafted about by the winds. Now we know that we simply let in an unusual number of hungry mosquitoes, some of whom having previously bitten malarial subjects, harbored plasmodia malariæ; and not to any great extent or from any considerable distance brought by the winds, but attracted by the light, flew in of their own accord, from the shades of the trees and still deeper shades of buildings, hard by, to which they had retreated for protection against the sun's rays. Then, these small water areas, although not sufficiently permanent for the growth and multiplication of fishes or carnivorous insects, remained long enough to permit a generation of mosquitoes, from which successive broods were developed and their continuity assured, through the renewal, from time to time, of these pools by the rain-fall, so plentiful in this locality during their breeding season. Now, University lake, an extensive and permanent body of water, literally teems with fish of many species and predatory insects in great variety. Mosquitoes, formerly so abundant, are now so scarce that for our experimental stock we have been compelled to lay under contribution a chain of puddles formed by the lake's intermittent overflow, and a pool which formed after every considerable rain-fall in a dependent portion of the bed of a drain that passes through the University's botanical garden.

The Physician in the History and Literature of Louisiana.*

By PROF. ALCEE FORTIER, Tulane University.

Mr. President, Ladies and Gentlemen:

When Dr. Chaillé kindly invited me to deliver the annual address at the commencement exercises of the Medical Department of the Tulane University of Louisiana, I felt highly honored and accepted the invitation, taking for my subject "The Physician in the History and the Literature of Louisiana." I fear now that I have been rash in doing so, and that I shall have a difficult task to perform. Many distinguished gentlemen have addressed the graduating class of our Medical Department, and it is no easy matter to find a pleasing theme for the occasion. Nevertheless, the interest that I take in the Tulane University of Louisiana as a whole, and in the oldest department of the university in particular, encourages me today, and it is with genuine pleasure that I find myself in the company of learned doctors of medicine. In spite of their number and of their proximity to me, I feel that my life is not in danger, although Molière has said: "You must never say that a person died of fever and of pneumonia, but he died of four physicians and two apothecaries." I know that Dr. Chaillé, who invited me to his house, will protect me. Have no fear, either, ladies and gentlemen, for the physicians of our day are pleasant people and do no harm to persons who are in good health. Indeed, the only physician mentioned in the history of Louisiana who was ever justly accused of having killed a man was the surgeon, Liotot, one of the murderers of Robert Cavelier de La Salle, and it is said that his weapon was a gun, not a knife or a prescription.

When the white men explored and settled the vast country watered by our great Mississippi they found among the Indians skillful medicine men and women who accomplished wonderful cures. Le Page du Pratz, in his History of Louisiana, relates how he was treated successfully for a sciatica by an Indian.

Although Iberville laid the foundation of Louisiana, in 1699, at the Old Biloxi, now Ocean Springs, I find no mention in our history of any physician, from the time of Surgeon Liotot in 1687, to the year 1719. In that year, on March 21, the "St. Louis," one of the King's ships, sailed for Louisiana, having on board the "Sieur Ballay, *chirurgien, éxilé par lettre de cachet.*" It is curious and interesting fact that the first physician whose name we find connected with the new colony founded by Iberville and Bienville should have been exiled by a *"lettre de cachet."* Why was not Dr. Ballay sent to the Bastille, which the distinguished French historian, Mr. Funck-Brentano, described to us so pleasantly last month? Was Louisiana considered a more agreeable prison than the Bastille, or did the Regent, Philip of Orleans, intend to confer a blessing upon the early colonists by sending by force a physician among them?

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*Annual address at Commencement Medical Department, Tulane Univ., 1905.

In the book of "Passages," which the Louisiana Historical Society has received recently from France, I find the following names of physicians on board the French war vessels which came to Louisiana:

1719—"Le Duc de Noailles," Le Sieur Tessendier, surgeon.

1720, May 28—"Le St. André," St. Hilaire, surgeon major; Alexandre, second surgeon, apothecary and botanist.

1720, August 10—"L'Elephant," M. Jean Baptiste Larmusian, surgeon major. His wife, Catherine Therèse Serenin, with three children, aged respectively, three, ten, and seventeen years, accompanied him.

1720, August 13—"La Gironde," Morand, surgeon major; Delaye, surgeon major.

1720—"L'Alexandre," Le Sieur Vieussens, surgeon; Roisier, surgeon major; Edward, second surgeon.

1720—"Le Chameau," M. La Frenaye, surgeon major.

1720—"La Seine," St. Jean and Brosset, surgeons.

1720—"Le Dromadaire," M. Bailly, surgeon.

1720—"L'Alexandre," Le Sieur Royer, surgeon major.

Of the above named physicians, two are found later in the colony, Drs. Alexandre and Brosset, and one, Dr. Larmusian, must have intended to establish himself there, as we see that his wife and his three children were with him on board the "Elephant," on August 10, 1720. The other names must have been those of ship surgeons, and in this regard, we may say that it is strange that so few names of surgeons are to be seen on the list of passengers in 1719 and 1720, while the names of the other officers are given fully.

If we turn to the book of "Censuses" of the Louisiana Historical Society, we find the following:

Fort Louis de la Mobile, June 28, 1721—Le Sieur Manadé, surgeon major; Le Nommé La Sonde (well named, indeed), surgeon.

New Orleans, November 24, 1721—Berard, surgeon major.

July 1, 1726, *Mobile*—Navarre, surgeon major.

July 1, 1726, *La Balize*—Ollivier, surgeon.

July 1, 1726, *Les Alibamons*—Milizan, surgeon.

July 1, 1726, *New Orleans*—At the Hospital rue du Quay, three male nurses, including the servant of M. Prat, physician, one gardener, one washerwoman, two negroes and two negresses.

Rue de Bienville, Michel Brosset, Pruyadon and Latour, surgeons. Dr. Brosset, had arrived by the "Seine" in 1720.

Rue de Bienville, Le Sieur Alexandre, surgeon major of the Hospital. He had arrived by the "St. André" in 1720, and was at that time second surgeon, apothecary and botanist. He seems to have prospered in the colony, for a little later he is mentioned as possessing a piece of ground measuring six arpents front on the Mississippi.

Census of New Orleans, July 1, 1727: Rue de Conti, M. Manadé, surgeon. He was at Mobile in 1721. On Conti street were also in 1727 our old friends, Drs. Alexandre and Brosset.

Census of New Orleans, January, 1732: Population, whites, 626; blacks, 258; Indian slaves, 9; total, 883. At the Hospital Rue de Quay were Duchemin, infirmier; Prat, Bizoton and Brosset, physicians, and Damaron, apothecary. Rue St. Louis, was Dr. Alexandre, surgeon of Hospital, and his wife, Madame Alexandre. New Orleans, with a population of 883 souls, had four physicians, one apothecary, and one male nurse. The census states that the inhabitants of the town possessed at that time 313 guns and 25 pistols, but does not say against whom they intended to protect themselves.

From the book of "Censuses" we learn also that Dr. Brosset had a plantation and was asking for permission to buy two negroes. His request was granted by the Governor of Louisiana, who said to him: *"Il est rangé"* (he leads a respectable life.")

In 1738, Dr. Prat, surgeon of the King's Hospital, whose name we see as early as 1721 in the census of New Orleans, asked for means to establish a garden of medicinal plants and a house for his residence. He requested that he have a salary of 2,000 lires, because the inhabitants were accustomed to be treated for nothing by the physician, and the latter had no resource but the favor of the King. In 1737, the sailor Jean Louis's Hospital had been established and was the beginning of our present noble Charity Hospital.

Concerning hospitals, some of the articles of a regulation of the King, dated January 1, 1729, appear very curious to us and may serve as a model for the management of our Charity Hospital:

"The physician shall visit the patients every day. He shall be accompanied by an assistant to the surgeon, who shall write down the bleedings ordered and the regimen. An apothecary and nurses shall accompany the physician, to report to him the effects of the drugs and anything that may have happened to the patients. The physician, as well as the surgeon, shall taste the soup and the wine, shall see the meat and the bread, and shall forbid that any fruit be given the patients, or any food unfit for them. The physician shall visit the pharmacy from time to time to examine the quality and quantity of the drugs. The surgeon shall oblige all his aides to sleep in the hospital, and if he lodges there he shall visit their room to see if they are there. If there is an assistant surgeon, he shall attend to this. No soldier shall be permitted to make a will in favor of the officers of the hospital where he shall be, not even in favor of the chaplain or of the latter's convent under pretext of pious legacy. All the officers of the hospital shall see to it that none of the patients or attendants shall blaspheme, curse, or use improper words."

I recommend the above to the Board of Administration of our hospital and to Dr. Batchelor and his assistants.

From the year 1738 to 1769, I see no mention of any physician in the History of Louisiana; but two students of medicine are named in 1752, Chastang and Dupont. In April, 1769, we find the name of Dr. Lebeau, whom his friend, M. Sorel, had requested to search and return to him a pirogue that had been stolen. Dr. Lebeau found a pirogue that agreed with the description given to him by M. Sorel, and obtained from Foucault, first judge of the Superior Council, an order that experts be named to decide whether the pirogue was M. Sorel's or not. The experts decided that it agreed with the description given by M. Sorel, and Dr. Lebeau thought he had obtained possession of his friend's property. But the Sieur Saligny, from the German coast, interfered and claimed the pirogue as his. In his petition he speaks harshly of Dr. Lebeau, and claims not only the pirogue, but damages and two days' pay for three Germans who had come with him to identify his property. Dr. Lebeau replied that experts have examined the pirogue, have measured it, have found a hole made by a knot in the wood and closed it by a plank, and now it is said the hole was closed by a plug. "A plug is not nailed; it is a cylinderical body, whose base is about equal to the point, and the piece of wood that closes the hole is three inches in diameter and two inches in depth. Is the Sieur Sorel in default for not having made a geometrical plan of the object? One of my negroes testified that in M. Sorel's pirogue there were one hundred pegs to close small holes, and in the pirogue in dispute two hundred. Now, that negro cannot count further than twenty. The story of this pirogue is a strange incident, for it would require all the pirogues in the universe to find two so exactly alike as this one and M. Sorel's. Men are all under the protection of the laws, but especially honest people, whose labor is useful to society, and not people whose occupation is to the detriment of society, like these coast runners, who, under pretext of bringing merchandise, carry disorder and death to the plantations by selling rum there. The police of a country should not only see that there should be no useless members of society, but also should remove the vicious members."

We see by the above petition that Dr. Lebeau was fearless and ingenious. His description of a plug is curious and interesting.

During the Spanish Domination no mention is made of physicians in our history; but, in 1802, before the transfer of the province from Spain to France and from France to the United States, we see the strange advertisement of M. Lartigue, dentist, who announces that he continues to practice his profession, and will receive in a superb *savane* horses or cattle at one dollar a head.

On April 19, 1805, the Legislative Council of the Territory of Orleans established the University of Orleans, and among the regents we see the names of Doctors Artin, Robelot, Montégut, Le Duc and Dow. On July 30, 1805, Mayor Pirot, who had succeeded Etienne de Boré, resigned his office, and Governor Claiborne appointed in his stead Dr. John Watkins. In his General Orders, after the battle of New Orleans, Jackson praised Dr. Kerr, hospital surgeon, who had volunteered his services, and Dr. Flood, for their medical skill and personal bravery.

It is pleasant to be able to say before this audience that the men of the medical profession in Louisiana have ever been patriots and have always taken an intelligent interest in public affairs. When Beauregard, our great chieftain, made pressing calls, in 1862, on his fellow-Louisianians to defend the Mississippi valley, it was his surgeon-general, the brave and chivalric Dr. Samuel Choppin, whom he sent as special messenger to New Orleans. Dr. Choppin addressed the men of our city and quoted a few fervid lines from "La Marseillaise." His ardor inflamed with patriotic zeal the men of 1862, who flocked under Beauregard's banner, and fought heroically at Shiloh on April 6 and 7.

Twelve years later it was another physician, the late Dr. J. Dickson Bruns, who, on September 13, 1874, addressed the eloquent and passionate appeal to the citizens of New Orleans which brought about the Revolution of the 14th of September. I take pleasure in quoting it once more as a model of civic courage:

"For nearly two years you have been the silent, but indignant, sufferers of outrage upon outrage heaped upon you by an usurping government. One by one your dearest rights have been trampled upon, until, at last in the supreme height of its insolence, this mockery of a republican government has dared even to deny you that right so solemnly guaranteed by the very Constitution of the United States, which, in article two of the amendments, declares that 'the right of the people to keep and bear arms shall not be infringed.' In that same sacred instrument to whose inviolate perpetuity our fathers pledged 'their lives, their fortunes, and their sacred honor,' it was also declared that even Congress shall make no law abridging 'the right of the people peaceably to assemble and to petition the government for a redress of grievances.' It now remains for us to ascertain whether this right any longer remains to us. We therefore call upon you on Monday morning, the 14th day of September, 1874, to close your places of business, without a single exception, and at 11 o'clock A. M. to assemble at the Clay statue, on Canal street, and in tones loud enough to be heard throughout the length and breadth of the land, Declare That You Are of Right, Ought to Be, And Mean to Be Free."

At the celebrated meeting which was held on September 14, 1874, around Clay statue on Canal street, Dr. Cornelius Beard stood by the side of the eloquent E. John Ellis and of the patriotic Robert

H. Marr, and called upon the people to defend their rights; to come armed to hold the city against Kellogg and all his hirelings, to make the whole city an armed camp, and never to leave it until the last of Kellogg's gang had left the city. "Their wives, their brothers," added Dr. Beard, "would bring them food and cheer them in their fight."

I have mentioned the above events in our history and the part taken in them by physicians to impress upon your minds, gentlemen of the graduation class, the fact that all men must fulfill their duty as citizens, that no profession has the monopoly in regard to practicing the duties of citizenship. First of all let us be men and citizens, and then physicians. lawyers, or teachers, and being men in the full sense of the term, that is to say, honest, courageous, and God-fearing, we shall surely be successful in whatever profession we may have chosen, in whatever sphere of life the Almighty may have been pleased to place us.

True manhood can be obtained only by the quest for the ideal, such as the quest for the Holy Grail made by the pure, the spotless knight of old; and if the ideal itself may never be reached, at least a useful work may always be accomplished by him who always has a noble purpose. Now, in order to possess that feeling which should urge you, gentlemen, to do the best you can, as citizens and as professional men, you should not be satisfied with attending solely to the duties and to the studies pertaining to your profession. Of course this should be your principal occupation, but you should look at the great world around you, you should understand the beauty of nature, of creation, and the grandeur of the Creator.

I have heard it said that often physicians have been materialists and have denied the spiritual side of humanity. I can hardly believe this, for their minute dissection of the human body has made them see that it is too wonderful an organism not to have proceeded from the hand of God, and besides, how often it has happened that to cure the ills of the body those of the mind had first to be treated? The successful practitioner of medicine is, therefore, the one who attends to the body, to the mind, and to the soul of men; the one who has the full confidence of his patients in his professional ability and in his moral character. So intimately connected is the physician with the inner life of his patient's family that he must be a true friend, a reliable confidant. The question has lately been agitated in French literature whether *"le secret professionnel"* (the professional secret) should always be kept by the physician. I answer emphatically yes, if he wishes to remain, what I am pleased to be able to say in perfect truth that he is, a friend to be trusted on all occasions, one whose kind look soothes the pain of the body, of the mind, and often of the soul, one who shares the happiness of those who have been brought back to health, and who consoles at the hour of grief when, in spite of all cares and efforts, what is immortal in man has been separated from the mortal.

In order to be prepared for any profession one should have a broad and liberal education, one should have the sense of the artistic, of the esthetic. Because a boy intends to become a physician he should not study at the High school or at the college of physics, physiology and biology. He should be acquainted with the great works of the ancient and of the modern literatures, which will give him an appreciation of the beautiful and a conception of the sublime. He is a narrow-minded man who attends solely to the technicalities of his profession, and such a man will lack judgment in the practice of his calling and will not understand some of the delicate, even if exaggerated, feelings which often bring about serious illnesses. I should like to see physicians and lawyers take an interest in art and in literature. It would be a relaxation from the duties of their professions, and they would add immensely to the mental culture and discipline without which there is no complete man.

Many physicians in Louisiana have paid some attention to literature, without impairing in the least their usefulness as doctors of medicine. I call attention here specially to our Creole physicians who were litterateurs of merit. Before the Civil war many wealthy planters and merchants sent their sons to France to be educated. After receiving a good collegiate education it happened often that the young men remained in Paris to study medicine, and thus there were in Louisiana a large number of distinguished physicians who were proud to affix to their names the letters D.M.P. (Doctor Medicus Parisiensis). They were all men of culture and were well versed in the Greek and in the classic works in French literature. Several of them deserve to occupy a high position among our Louisiana authors.

The first work in the literature of Louisiana is a short epic poem by Julien Poydras, on the campaign of Galvez against Baton Rouge in 1779. Then comes, in 1814, a tragedy, "Poucha Houma," by Le Blanc de Villeneufve, and later many dramas, histories and poems. It is probably as poets that the Louisianans of French origin and the Frenchmen residing in Louisiana have distinguished themselves the most, and we have in our literature some works which would do honor to any literature. Among these poets we are glad to mention three physicians: Dr. Charles Deléry, Dr. Charles Testut, and Dr. Alfred Mercier.

Dr. Deléry wrote charming lyric poems and also a work in the style of Juvenal, *"Les Nèmèsiennes Confédérées,"* published in 1863, and which stigmatizes Butler's infamous rule in New Orleans. He published also a comedy in verse, *"L'Ecole du Peuple,"* which is a keen satire of the carpetbag regime in our State. A very valuable work of Dr. Deléry's is *"Les Chroniques Indiennes,"* where the author gives an interesting account of the customs of the Indians.

Dr. Testut was a very prolific writer. His best poems, *"Les Echos"* (1849), are graceful and usually sad, and his subjects are principally meditations or descriptions of touching domestic scenes. He wrote several novels, of which the most interesting is *"Les Filles de Monte Cristo,"* a continuation of Dumas' thrilling romance. His *"Portraits Littéraires,"* is an important work of criticism of the French writers of Louisiana before the Civil war.

Dr. Alfred Mercier was the most versatile of our authors. He was a poet and a novelist of talent, and he was also an excellent physician and a man of charming disposition, always unselfish and kind. He died in 1894, aged 78 years. In his long career he had seen all the miseries to which man is subject, but he had met also with noble sentiments, and he was one of those who believed that humanity is not entirely bad, and that vice can be corrected by kind words. It was this benevolent and enlightened philosophy which was the principal charm of his writings. He seemed to have considered poetry as a relaxation from his more serious duties, and he called the Muse to him, not to confide his sorrows to her, as Musset, the author of the *"Nights,"* but to take his flight with her toward those regions where are to be found charming children, beautiful young girls, and sweet smelling flowers. His early poems are gentle and graceful, and his later ones are full of force and tender melancholy. One of his novels, *"L'Habitation St. Ybars,"* gives a very interesting description of life on a large plantation before the civil war.

Dr. Alfred Mercier was the founder, in 1876, of the Athénée Louisianais, a literary society established to preserve the French language in Louisiana, of which his brother, Dr. Armand Mercier, the distinguished surgeon, was the first President, and General Beauregard, the second President. Among the most zealous members of the Athénée Louisianais, and among the ablest French writers of Louisiana, besides Drs. Armand and Alfred Mercier, and Dr. Deléry, already mentioned, were Drs. Charles Turpin, E. Dupaquier, J. G. Hava, O. Huard, Sabin Martin, J. G. Dell'Orto, and Dr. Gustave Devron. The latter was also, for several years, First Vice President of the Louisiana Historical Society, and published important monographs on historical subjects.

Another physician who was a very able practitioner of medicine and a French writer of merit, was Dr. J. M. Durel. He was the editor of the *"Carillon,"* a literary journal in which were published most amusing and sarcastic articles about the men who, during Reconstruction times, leagued themselves with ignorant negroes to plunder our State.

In this review of the part played in the French literature of Louisiana by our physicians, I do not include those who are still living, and I do not speak of the purely technical medical works, although some, as the monographs of Dr. Charles Faget on yellow fever, are so well written that they might be included in the term literature. The physicians of Louisiana have always been celebrated for their scientific attainments, and many of them have produced valuable works dealing with professional subjects. I am not competent to discuss them, but I wish to mention here the name of one of our most laborious and distinguished writers on scientific subjects, Dr. Joseph Jones, who was for many years one of the professors in the Medical Department of our University.

If I had time I might speak of some interesting literary works written in English by physicians of Louisiana, but I believe that I have proved the statement I have made that professional men would profit greatly by devoting part of their time to literary, to aesthetic studies. Dr. Armand Mercier was one of the ablest surgeons we ever had in New Orleans, and yet he was President of a literary society. Dr. Charles Turpin was a very successful physician, and yet he was a devoted member of the Athénée Louisianais and a very graceful writer.

Pay some attention, gentlement, to the study of the masterpieces of literature. Let not your practice, however large and lucrative it may be, from the very moment you leave this university prevent you from giving a little time to reading the productions of a Dante, of a Shakespeare, of a Cervantes, of a Goethe, of a Molière. Above all, read the works of the great French comic writer. Do not feel hurt at his amusing caricatures of the physicians of his time, as portrayed in *"Le Médecin malgrè lui," "L'Amour Médecin,"* and *"Le Malade Imaginaire."* His Sganarelle and his Argan, his Bahis and his Desfonandrès, are buffoons, but they have yet a touch of genuine human nature and are most comic. How amusing is the reception of Argan in *"Le Malade Imaginaire"* into the learned profession? How well he answers the questions asked him by his examiners, who all dance around him and sing:

"Benè, benè, benè, benè, respondere
Dignus, dignus est intrare
In nostro docto corpore."

The candidate swears to obey the rules of the profession, and the Dean puts on his head the Doctor's helmet, and says in wonderful Latin:

"Ego, cum isto boneto
Venetabili et docto,
Dono tibi et concedo
Virtutem et puissianciam
Medicandi,
Purigandi,
Seignandi,
Percandi,
Taillandi,
Coupandi
Et occidendi
Impure per totam terram."

While playing *"Le Malade Imaginaire,"* Molière fell dying on the stage, and the physicians of his time were foolish enough to say that it was the punishment of God for his attacks against their sacred profession. They should have laughed at some burlesque and witty scenes in the great Molierè's works and should have forgiven him on account of the admirable lessons given to men of all times in *"Le Misanthrope," "Le Tartuffe," "Les Femmes Savantes," "L'Avare," "Ecole des Femmes," "L'Ecole des Maris,"* and many other remarkable comedies.

If the physicians of the Seventeenth Century were displeased with Molière, those of the Eighteenth must have been furious with Le Sage, who created in his *"Gil Blas"* the celebrated Dr. Sangrado, who pretended to cure all ills with hot water and blessings, but yet dispatched his patients so quickly to a better world that he ruined the notaries of his time by not giving them the time to reach the bedside of the sick people who wished to make their testaments.

Of course, ladies and gentlemen, there will never be Sangrados among the young physicians who are now on this stage. On the contrary, they will all be like Balzac's admirable Dr. Benassis in *"Le Médecin de Campagne"* ("The Country Doctor"), self-sacrificing, learned and noble, a blessing to the poor and to the suffering.

In order to be like Dr. Benassis you have only, gentlemen, to follow the good example given you by your estimable professors, to be always worthy of them, and of the other members of the medical profession in our State, in the past and in the present, to be worthy of the Tulane University of Louisiana whose President has just conferred upon you the high and honored degree of Doctor of Medicine.

Pneumonia.

By THOS. A. ROY, M. D., Mansura, La.

Some years ago pneumonia was classed as an essential fever, with local manifestations in the lungs; today, due to researches made by blood cultures, we know that this disease is caused by a specific coccus, called the pneumococcus, and which does not only inhabit the lungs during an attack, but is found in the circulation. Therefore, it results that pneumonia is an infectious disease, caused by specific bacteria, characterized by well known constitutional disturbances, not here necessary to enumerate.

Pneumonia today is the most fatal disease in America, superceding tuberculosis in its death rate. Of the causes, which increase the alarming percentage of deaths, we find, from a consultation of statistics on this subject, that intemperance produces the largest death rate, to-wit: Among the total abstainers, 25 per cent die, among the hard drinkers, 45½ per cent die; 191 persons out of every 100,000 population in America died of pneumonia in 1900. In 1860 the death rate was 10¾ per cent; in 1890, 18¾. It is manifest from these statistics that pneumonia is increasing its percentage of deaths, despite our progressive and determined efforts. Notwithstanding the multiplication of devices and means at our command, the reaper silences huge multitudes of humanity in increasing numbers as the years pass by, showing that environment, mode of living, intemperance, dissipation and unhygienic surroundings, are factors in producing a condition necessary to receive the cause and develop pneumonia, and produce its great fatality.

Other causes to be enumerated among those producing the large death percentage are found in improper hygienic environments, such as lack of ventilation, improper food and clothing, uncleanliness, sudden change of temperature, but the main cause of pneumonia in its total, is to be found in the metereological changes, and in the individual, whose resisting powers are lowered, and whose vitality is at a low ebb. Pneumonia seeks its great death percentage among those who are otherwise at a low tide of vital energy, especially the old and the young.

Another cause of pneumonia is its contagiousness, and will here cite a few experiences: In 1902, while treating a case of pneumonia, in a family of nine persons, I had occasion to see the entire family go down with the disease, except one little girl of nine, not even sparing the baby in the cradle. In another family, in 1903, I had occasion to treat five members, out of seven, at the same time. In another family of three, two cases occurred. In another of five, three cases were seen. These numerous instances of proof of the the contagiousness of pneumonia is apparently qualified by certain observations made; I refer to the total disregard of these families from observing the rules of proper ventilation, of keeping the apartment from crowds of people, and invariably overheating, creating a medium for the transmission of a contagium, exposing the family to too warm apartment, to be quite frequently out of doors in the performance of domestic duties, and these frequent entrances and exits from the apartment of the sick is no doubt propitious to the development of pneumonia; in this connection, it is also well to state, that most families, when one is sick with pneumonia, will sit up, lose sleep, eat irregularly, break up the habits of the individual and thereby lower his vitality and in a way cultivate his system to receive the cause, which cause might not be transmitted were the individual in a good physical condition; this observation may, in a way, qualify the supposition of the contagiousness of pneumonia.

I will now call your attention to a few, not generally known, phenomena of pneumonia; I refer to abdominal pain in pneumonia, as this symptom can easily be mistaken for another trouble than the one actually at work. Herrick, who has drawn renewed attention to abdominal pain in pneumonia, illustrates it by clinical observations. The anatomical explanation is as follows, as stated by the author: "The lower six intercostal nerves supply the abdominal wall as well as part of the peritoneal and diaphragmatic pleura. Irritation of this nerve in its course, might readily cause pain which would be referred to its distribution, *i. e.,* the abdomen. Particular note should also be made of the eleventh intercostal nerve, which is distributed to the iliac region, and irritation of this nerve has often caused suspicion of appendicitis." The writer calls your attention to this condition only to help us in explaining the abdominal pain all children manifest during cases of pneumonia, and which we are too prone to disregard or suppose it be an abdominal condition, when, as a matter of fact, the cause is in the lungs.

It has come to the observation of us all to meet with acute pain in pneumonia located in the right shoulder joint and the abdomen. This, by the same author (Herrick), is explained by being an irritation of the phrenic nerve, and the pain is radiated along its course.

Of the treatment, I know none except it be to primarily surround your patient with the best possible hygienic environment, which alone will save a good percentage; avoid over-medication keep the temperature of 104 down with mustard or simple bath; use mustard plasters and morphin to control pain, the latter sparingly; I will mention muriate and carbonate of ammonia and creosotal only to condemn them. They are not only unnecessary, but materially injurious. Give strychnin, 1-60 every three hours, and keep the bowels open every day. Feed lightly and give the poor fellow a chance by not nauseating him with half a dozen expectorant decoctions. Keep the room ventilated; you cannot give him too much fresh air; keep the neighborhood away from the sick room, where they congregate to smoke the pipe, drink coffee, spin yarns and perfume the apartment with malodorous exhalations.

Empyema.

By Dr. T. A. ROY, Mansura, La.

This serious condition demands heroic effort on the part of the attending physician, if he will save the life of his patient, or months of suffering convalescence. Of means at our command, I have no hesitancy in saying that there is but one, having tried both of the methods of relieving this condition, to-wit, by repeated aspiration, and by resection.

Notwithstanding five cases aspirated by the writer, followed by perfect recovery, I still would not perform this operation today, because of the length of the convalescence, the uncertainty of the success of removing, even at best, but a fraction of the quantity of the pus. The means at our command appealing most to my judgment, is that of resection of a rib or as many as the condition requires to properly drain the cavity. The method is simple, and is fully set forth in all text-books,—one point not generally known which may be spoken of here, is the advisibility of dispensing with the drainage tube on the supposition that that tube may act as a mechanical irritant to the tissue, with which it comes in contact. The method I would suggest is the Brinkman method, which consists in the resection of the rib or ribs in the usual manner, and to suture the edges of the skin with those of the pleura, and when all signs of pus has disappeared, as can be ascertained by physical signs and the general condition of the patient, the edges of the wound are freshened and brought into proper apposition to promote union, the wound to be closed by suture or with adhesive strips.

My idea in advising resection instead of aspiration is to convey my experience in six cases, and to set forth the difference in the length of the convalescence, of the five cases aspirated. While all the cases recovered, not one required less than six months of tedious convalescence. Of the case in which resection was made, the patient's temperature of 102° for 66 days touched normal the day following the operation, and the wound allowed to heal in ten days. In said ten days the patient, a boy of three years, increased five pounds in weight.

Clinical Report.

Cavernous Angioma of the Scalp.

By REMY G. DUCOTE, Bordelonville, La.

Angioma is a vascular tumor, composed mainly of blood vessels, or spaces filled with blood. This is of no rare occurrence, but is seldom seen on the scalp.

About twelve years ago, I. J. G., twenty-six years old, received a blow on the neck, just about at the division of the occipital from the external carotid; produced by a stick falling from a height of 25 feet.

The patient was stunned for a few moments, but soon recovered with no serious injury, except the skin was bruised. No swelling or severe headaches developed, until some few years afterwards. A slight tumor began to grow until it has reached its present size.

Previous to the growth of the tumor, patient suffered a great deal from headaches, which soon disapeared when the tumor began to grow.

The young man is now engaged in photography, leads an active life and enjoys excellent health.

Symptoms. The tumor is pulsative, and synchronous with the heart beat, also a souffle is heard with the phonendoscope.

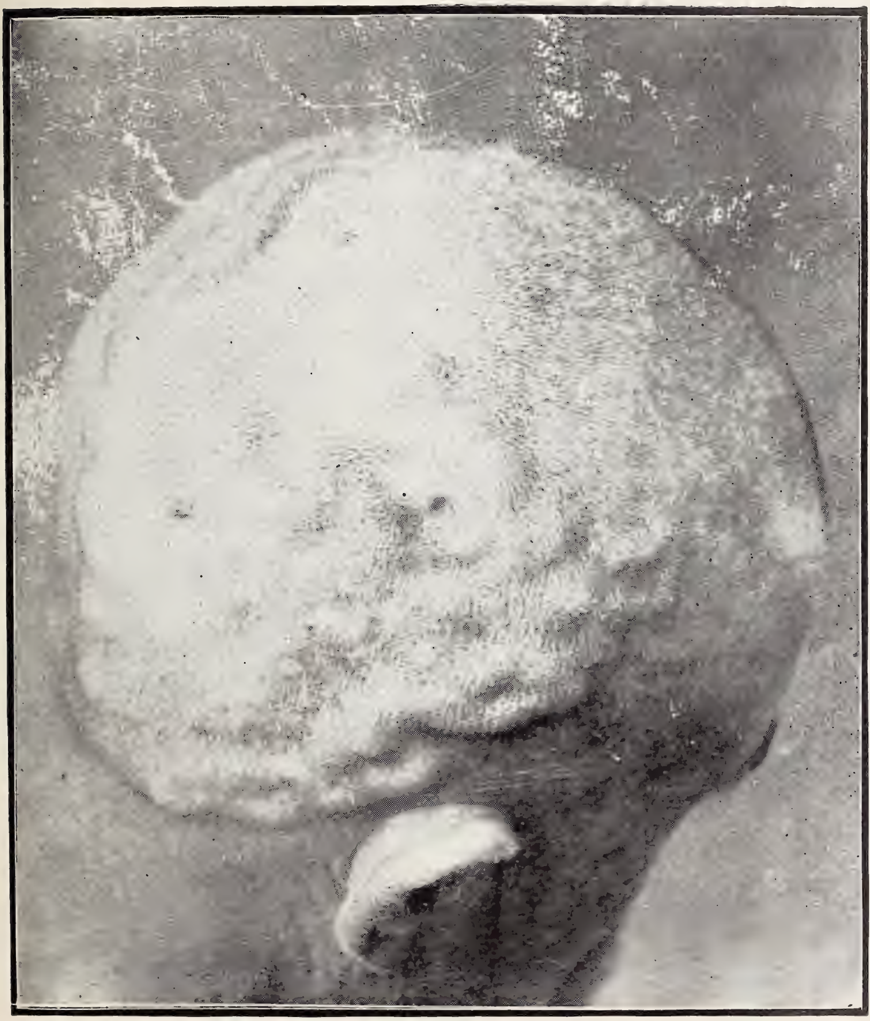
Pathology. The enlargement of the tumor is due to the blow, which injured the walls of the blood vessels to such an extent that the tonicity was lost, and then the gradual dilatation began where the resistance was least.

The trouble developed first in the occipital, near its junction with the carotid. At present the occipital, with its branches, the posterior auricular and the posterior temporal, are all involved, and produce a tortuous swelling over the scalp, as seen in photograph.

The enlarged vessels over the scalp are eroding the cranium, owing to their action over the bone.

The case is reported to show the great surgical technic demanded, because it is seldom seen over the scalp; also on acount of the slow growth of the tumor, and unimpaired health of the patient.

New Orleans' Medical and Surgical Journal,
July, 1905.



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REMY G. DUCOTE, M. D., Bordelonville, La.

Louisiana State Medical Society Proceedings.

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In charge of DR. P. L. THIBAUT, Secretary, 141 Elk Place.

Annual Address of President.

By CHAS. CHASSAIGNAC, M.D., New Orleans.

By virtue of the office with which this society has honored me, it devolves upon me to deliver an address at this our annual meeting. Should I succeed in interesting or impressing you even to a moderate extent, duty will have become on my part a pleasure.

As so much of the time at my disposal for the preparation of this paper was consumed in choosing its subject, I may be pardoned for saying a few words about the difficulty encountered in selecting it. Believing with Wendell Holmes that an address "ought to be something which all can understand, about something which interests everybody," I thought of a number of topics, actually beginning to write on some of them, but abandoned them in turn for not coming up to the specifications mentioned: I feared that one might be too dry, another too frivolous; that I might be misunderstood in my handling of some or might fail to interest one part, if not all, of my audience with others. The time-honored custom of inviting the public to this session served only to increase the dfficulty, for, the subject having as a matter of course to be in the medical line, it was far from easy to evade the Charybdis of being too elementary for my medical auditors while escaping the Scylla of too much technicality for the rest of my hearers.

Finally, I decided upon "The Role of the Mosquito in the Propagation of Disease, Especially Malaria", concluding that this subject even indifferently handled could not fail to interest the various members of this intelligent assembly as students, as citizens, or as advisers of the people. The decision to consider the relation of the insect particularly to malaria was based upon the fact that this has been studied for a longer time, by a greater number, over a larger territory than other phases of the mosquito question. True, it should be added, a great deal more has been written about it. Before this society, four years ago, Prof. Beyer read a valuable address on "Mosquitoes and Their Relation to Disease", which embodied an elaborate description of the insect and its habits. You surely all know a great deal about it—and this was the chief objection to my selection. My defense is that often much can be accomplished through iteration and reiteration; also when, on the one hand, the question is sometimes put, even by physicians of ability, "what do you think of the mosquito theory?" and, on the other hand, the assertion that "the propagation of disease by the mosquito is no longer a theory, but a fact," is yet to be heard, both show that by some at least the point is still considered as either debated or debatable.

What is a theory? The dictionary calls it a hypothesis; a speculation; the philosophical explanation of phenomena. A broader definition would be that a theory is a working plan by means of which certain given occurrences are speculatively explained.

If now we look up the word "fact" we find it defined as a reality, actuality, truth. Consequently we can say that any theory which can be demonstrated to be true becomes a fact.

Let us see, then, if we can show it is a fact that the mosquito can or does propagate disease, especially malaria; in other words, let us study the evidence impartially and try to conclude whether mosquitoes are only abominable nuisances, which nobody can deny, or, in addition, a serious menace to the health and prosperity of a community. Theoretically the latter idea is not new; excellent articles were written both before and since the discovery of the causative agent of malaria, suggesting that mosquitoes and other insects could propagate disease, but we are not concerned with these; we are not dealing with theories; we must adhere to our text and endeavor to prove our point by the brutal force of facts.

Malaria is probably the most generally distributed of all endemic diseases and has been from time immemorial the cause of untold suffering, considerable loss of time and money, and a serious sacrifice of life. As a natural consequence its cause has been sought long and diligently, while numerous theories have been evolved to explain its origin. The derivation of the word indicates that it was first thought to be due to bad air, but nearly two hundred years ago observers were already led by the study of conditions favoring its development to believe its pathogenic agent to be a parasite. Different persons at various times claimed to have discovered the identity of the latter, but sooner or later were forced to abandon their pretentions.

Laveran, to whom humanity owes a large debt of gratitude, in 1878, had the opportunity at Bone of performing several autopsies upon victims of pernicious malarial attacks and was struck by the fact that a special alteration of the blood, a melanemia, was characteristic of these cases. He found that this change in the blood was due to the presence of certain pigmented elements which it contained and the microscope revealed that these were spheric and crescentic bodies which accompanied the blood corpuscles themselves. On November 6, 1880, he demonstrated in the fresh blood of a patient at Constantine the presence of what he described as the principal forms of the hematozoa of malaria. This parasite belongs to the order of protozoa, which is one of the lowest class of the animal kingdom, comprising organisms that consist of cells, or groups of cells, not differentiated into separate tissues; its subclass is that of the sporozoa. It presents itself under three types: 1°, ameboid bodies, the most common form, which are spheric in shape; 2°, crescentic bodies, which are colorless and transparent except at the middle, where are massed pigmented granules identical with those found in the spheric bodies; 3°, flagella, motile filaments coming from the spheric bodies and whose motion is quite lively, reminding one of diminutive eels which, held by their caudal extremity, are trying to disengage themselves. The exact form the protozoa assumes differs, however, according to the stage of the fever cycle they represent.

These observations of Laveran were soon confirmed by the most competent men all over the globe. The plasmodium, as it is now denominated, though zoologically the term is not strictly accurate, has since been found in the blood of malarial patients in Europe, Asia, Africa, America, and Oceanica; furthermore, today any one at all equipped for microscopical work can recognize it and may find it. The ease and thoroughness with which it can be seen is well illustrated by one of its patient observers, Major Ross, who gives the following graphic account of how he watched a free flagellum continuously for three hours under the microscope, in a blood preparation. "At first," he says, "it wriggled about for twenty minutes so that I could hardly follow it. Then it brought up against a phagocyte and remained there so long that I thought the phagocyte had seized it. Not so; it was neither killed nor sucked in, but was actively engaged in attacking the phagocyte. The flagellum kept at this for a quarter of an hour, and then wriggled away in the direction of another phagocyte. Into this second phagocyte it pushed in several places with one of its ends, and the phagocyte seemed to rear up and try in vain to get around and envelop the flagellum. At last the phagocyte seemed to give up the struggle and flattened itself against an air bubble, the flagellum still attacking it. After fifty minutes and when the flagellum seemed to be getting exhausted, a very curious thing happened. A third phagocyte approached, coming rapidly across the field, but it had no sooner got near than the flagellum left its fallen foe and attacked the new one, holding on to it like a snake on a dog. In one minute the third phagocyte turned sharply around and quickly made off; it went across a whole field, the flagellum holding on to it. This continued for five minutes, after which the flagellum left the phagocyte. By this time the flagellum had become more visible, its movements became gradually slower until, at the end of three hours, it finally curled up and ceased to move."

Many other interesting details concerning the various forms of the germ, their mutations and their significance, might be entered into, but they would lengthen this paper unduly while they have little to do with the argument proper. It is important to bear in mind, however, that whenever a blood examination is made with care, under proper conditions, just before or during a malarial febrile paroxysm, in a person to whom quinin has not been administered recently, *some of these parasitic elements are always found and they are never met with outside of malaria.* Repeated experiments have confirmed both the positive and the negative part of the proposition.

A further proof of the relation of cause and effect which exists between the parasite and malaria lies in the fact that, under the influence of quinin medication, the hematozoa usually disappear simultaneously with the cure of the fever. It should be stated, as additional evidence, that, when blood containing malarial protozoa has been injected into the veins of a person not infected with malaria, the disease has been transmitted thereby, and, what is very striking, of the same type as that represented in the injected blood.

The poison of malaria once discovered and its presence demonstrated in the blood of man, the next point was to find whence it came, how and where it existed outside of the human body. It could not be found in the blood of other animals nor could they be inoculated successfully with it. Attempts to find it in the air, in water, in the ground, or to make cultures of it in various media always failed. This led to the conclusion that the microbe did not exist outside of the body in the same forms as it did in human blood and to the suggestion that an intermediate host might be found, as had already been done with other parasites. It is not surprising that Laveran should have suspected the mosquito of being the guilty intermediary, especially as its role in the propagation of filariasis had been demonstrated already by Manson and was generally accepted.

Many facts concerning malaria, well established before the discovery of the plasmodium, lent color to this idea, for they all could be connected with the probable presence or absence of mosquitoes, as the case might be. For instance: people remaining on shipboard at a reasonable distance from shore were apt to remain free from malaria in unhealthy localities, even if they only avoided the land particularly at night; during some military expeditions in malarial regions, while the land troops were decimated by malaria the naval forces remained practically exempt; the worst period for malarial attacks is from June to November, contemporaneously with the activity of mosquitoes; swamps, marshes, rice-fields, pools and ditches have long been known to be necessary to the production of malaria, in fact stagnant water of any sort is favorable to its development, while running water does not favor it; proper soil drainage diminishes and arrests malaria at the same time that it leads to the disappearance of mosquitoes; inhabiting high altitudes, where mosquitoes are known not to exist, is inimical to malaria; night air has always been dreaded in reference to malaria.

The hypothesis concerning the role of the mosquito in malarial transmission was taken up by Manson, to whom the notable and previously noted researches about filariasis gave great authority. He concluded that the malaria germ, like all parasites, comes from without; that in natural conditions it does not pass, like the germ of smallpox or of measles, directly from one human being to another. There was abundant evidence to show that it does exist outside the human body and independently; also, there was ample evidence to prove that it can multiply outside and multiply there indefinitely.

There were open two ways of searching for the extra-corporeal malaria germ: First, to grope about in external nature, more or less blindly, trying to find some form which might be supposed to be the object sought; secondly, to assume that the malaria parasite as found in the blood of man is present there as a normal circumstance in its life-history and to follow it out of the human body, tracing it back to man again.

It was clear that the plasmodium was not driven to enter man for the reason that man is in any way necessary for its existence as a species. It was known that malaria abounds where man is rarely or never seen—in tropical wildernesses; this could not be were man necessary for its development and multiplication. So far from man being necessary for the evolution of this parasite, if anything, his presence has been inimical to it; in towns and other places where men congregate, malaria is infinitely rarer than in the open country, where man is a comparatively insignificant feature. Manson was, therefore, forced to conclude that when the parasite does enter man, it does so as finding in him a suitable alternative host from whom it can escape and extend as a species, furthermore that man is only one of the media in which this parasite can exist, and that in regard to it there is reciprocity between him and those other external media or medium.

Casting about for an agent that would meet the requirements of the case it occurred to him, as it had already occurred to Laveran, that as the plasmodium is a passive blood parasite, its escape from the human body might be effected on the same principle that the escape of the passive muscle parasites is effected. As the latter obtain their opportunity by being swallowed by some flesh-eater—some carnivorous animal—he thought that the former might get its chance of development by being swallowed by some blood-eater, some suctorial animal, such as the flea, the bug, the leech, the sand-fly or the mosquito. The geographical distribution of malaria and other very manifest considerations seemed to point to one or the other of the last two as the most likely liberating agent, and the notorious association of malaria and mosquitoes with damp and stagnant water seemed to indicate more especially the latter insect.

Major Ronald Ross, who was then in India, joined in the search and succeeded in tracing the plasmodium from man to the mosquito. He found among his patients a Sepoy, who was suffering from malarial cachexia, and in whose blood the crescent form of the plasmodium abounded; several crescents could be found in nearly every field of the microscope. He placed this man under a mosquito net, introduced mosquitoes which he had reared from the eggs and which consequently could not have been infected previously, then collected the insects after they had filled themselves with the patient's blood. He subsequently made systematic examinations at short serial intervals of the blood in the malariated mosquitoes' stomachs. As a result of a prolonged study of the subject, Ross found that not only the ingested crescents were not killed and were not digested by the stomach of the mosquito, but that, with the exception of an insignificant proportion, they all rapidly proceeded in development; in twenty minutes almost all became spheres and after thirty many flagella could be seen.

The malaria parasites after going through the full cycle of development in the stomach of the mosquito, penetrate its walls and appear in large numbers in the tissues of the insect, finally reaching the salivary glands.

Now, as we already have followed in sequence, though briefly, the identification of the malaria germ in the blood of man and its asexual evolution therein; next, its appropriation by the mosquito through the suction of infected human blood; then its sexual development in the stomach of the insect and its migrations up to the time of its location in the salivary glands of the intermediate host, a very brief description of the mouth parts of the mosquito and their function will be sufficient to explain clearly the manner in which is accomplished the completion of the vicious circle, namely, the introduction of the poison in the human organism. Elaborate anatomical details would be superfluous here, but have been published by Nuttall and Shipley and, also, by Prof. Beyer in an article which appeared a year ago in our local medical journal.

The offensive weapon of the mosquito is composed of a narrow upper lip and a long lower lip; the latter forms a sort of gutter in which lie five lancet-like pieces, one of which is a tubular prolongation perforated by the salivary duct, which opens at its end. In the female this whole proboscis, with the exception of the lower lip, is made to pierce the skin. Before blood is extracted from the victim by means of a pump-like apparatus, and at the same time that the puncture is made, saliva is injected into the wound. Hence, whenever the salivary glands are infected, parasites are introduced directly in the tissues, just as with a hypodermic needle, and the process of infection is completed by the entrance of protozoa into the circulation.

It may not be amiss to lay stress at this time upon the fact that the occurrences of fascinating interest, which I have tried concisely to picture, are not suppositions, but have been seen and confirmed frequently by numerous impartial and cautious observers in different parts of the world; also that they can be witnessed at any time by anyone possessing sufficient skill and the necessary equipment.

The first proof of the inoculation of man with malaria by mosquitoes, was furnished by the experiment of A. Sola at the Hospital of Santo Spirito in Rome, but I shall give a brief account of only two among the best known and most reliable of the tests made, one confirmatory of the other, though attacking the proposition from opposite sides, as might be said. Both were reported at length, by Manson, in the *London Lancet,* in 1900.

Two Roman physicians, Drs. Bignami and Bastianelli, by repeated and careful microscopic examination of the blood, selected patients with pure benign tertian malarial fever, as it would have been wrong to experiment with either a more dangerous or a more stubborn type of the disease. Mosquitoes were fed upon these patients and were then placed in small cylindrical cages made of netting stretched on a wire frame, which were forwarded from Rome to London, arriving in about forty-eight hours. Some died on the road, but a fair portion arrived in a vigorous condition. Mr. Thurburn Manson, of Guy's Hospital, volunteered for the experiment. He was 23 years of age and had never been in a district supposed to be malarial. His blood was tested and determined to be free from malarial parasites. He fed a number of the Roman infected mosquitoes on his fingers and hands at the end of August and the beginning of September. By the middle of September he commenced having chilliness, lassitude, headache, pains in the back and bones, and a slight elevation of temperature. All the symptoms soon became exaggerated, and his temperature finally rose to 103.6°. Well-marked splenic enlargement could be detected readily. Blood examinations subsequently revealed the presence of tertian parasites, the same kind as those infecting the mosquitoes used in the experiment; they were verified by Manson, Frederick Taylor, Lieut. Col. Baker, Dr. Galloway, Mr. Watson Cheyne, and Mr. James Cantlie. Quinin was given subsequently in doses of 5 and 10 grains during several days. The temperature became normal, the splenic enlargement gradually disappeared, parasites could no longer be discovered in the blood, the patient's appetite returned, and he regained his usual good health.

So much for the positive side of the proposition. Now for the negative.

About five years ago a wooden hut, constructed in England, was shipped to Italy and erected near Ostia, at the mouth of the Tiber, at a jungly, fever-haunted spot, teeming with insect life, and ascertained to be intensely malarial; the permanent inhabitants thereof all suffer from malarial cachexia, and healthy laborers, who come there for the harvest, soon contract fever. Dr. L. Sambon, Dr. G. C. Low, Signor Terzi, and their two Italian servants took up their residence in this hut early in July, and lived in it until the end of October, that is, during the period of the greatest prevalence of malaria. They did not take a grain of quinin, went about freely during the day, though remaining on their guard against anopheles mosquitoes, but they were careful to be indoors from sunset and sunrise. The only other protection against fever, to which they resorted, consisted of wire screens in doors and windows and mosquito nets around their beds, by way of extra precaution. The experimenters and their servants enjoyed perfect health during the entire period, "in marked contrast," says Manson, "to their neighbors, who were all ill with fever or had suffered malarial attacks."

These experiments were so simple, so clear, so convincing, that

I need not expatiate upon them. Together with the work of Laveran, Ross, Grassi, Manson, Celli, Bignami, Bastianelli, of the Mosquito Commission of the Orleans Parish Medical Society, composed of Prof. Beyer and Drs. Pothier, Couret, and Lemann, they furnish irrefutable and unimpeachable evidence, more than ample, to convict the mosquito of being guilty of transmitting malaria.

Besides, corroborative evidence is not lacking. Elwes relates in the *British Medical Journal* that when on a hunting expedition in a very malarious district of the Bhotan Teral, he and two Europeans of his party escaped malaria by keeping within mosquito curtains from dark to sunrise, while the two other Europeans and nearly all the natives, who did not take these precautions, suffered so severely from malaria that the camp was unable to march after three weeks in the district.

Ismailia is a little city near the Suez Canal, and, being situated in a sandy desert, for a time it was found difficult to account for the great prevalence of malaria in such a place. Investigation revealed that the subsoil water is so near the surface that it produces miniature marshes, which rise and fall with the fluctuations of the distant Nile. Mosquito larvæ were found therein, and many malaria-bearing anopheles were found in infected houses. During 1902, about 2000 cases of malaria occurred in Ismailia. A campaign against the mosquitoes was instituted, and during the next year, 1903, there were only 200 cases, or one-tenth as many, while by 1904 the town had become practically free from malaria.

Among the confirmed criminals condemned to labor in the salt works at Corneto, Italy, the infection was both general and grave and had been considered invincible. During the year 1900, the cases of malaria amounted to 395. The prison officials having adopted merely mechanical protective measures against mosquitoes, the result was that by 1903, three years later, only a single case occurred during the whole year.

Numerous similar instances abound, but as it is not my purpose to write an exhaustive treatise on the subject, I shall cite no others, for my aim is to avoid tiring you. It will be sufficient to add, in reference to malaria, that investigations all over the world have shown that, wherever the disease exists, the species of mosquito known as anopheles are found. It does not follow that wherever there are anopheles there must be malaria, for it should be borne in mind that mosquitoes do not generate the disease, but have first to suck in its germs before they can transmit the malady.

While, for reasons already given, your attention has been called chiefly to the role of the mosquito in transmitting malaria, it is well to remind you that even before the nature of the poison of malaria had been discovered, it had been demonstrated that this pestiferous insect was responsible for the propagation of filariasis, a disease due to the presense of thread-like bodies in the blood, and causing many distressing phenomena. More recently, other species of mosquito have been discovered to transmit yellow fever and dengue, while analogous instances of the transmission of disease by insects are found in Texas fever, derived from the tick; trypanosoma, or sleeping-sickness, from the tsetse fly; recurrent fever, from the bedbug.

However, the only other point upon which I shall dwell at all, is the relation of the stegomyia mosquito to yellow fever. While the connection can not be demonstrated as conclusively as in malaria, for the simple reason that the germ or parasite of yellow fever has not yet been isolated beyond question, the consensus of opinion among all those who have made scientific observations on the subject, is that the female stegomyia can, and does, play the part of intermediate host and of chief transmitter of yellow fever. The only point still under controversy is, if the mosquito is the only means of transmission—and that is another story.

The experimental evidence collected in Havana in 1900, relative to the subject, is of enormous weight and importance. Non-immunes placed with yellow fever patients at different stages of the disease, also brought in contact with infected bedding and clothing used and soiled by patients with yellow fever, remained perfectly well when the precaution was taken to protect them against the bite of mosquitoes. On the other hand, some of these same non-immunes, whose consent to be bitten by infected mosquitoes was obtained, were stricken with the fever as a result of the bites. One of these, Dr. Lazear, a member of the Board of Medical Officers who investigated yellow fever under the auspices of the United States Army, fell a victim of his zeal and a martyr to science, when he succumbed from yellow fever bravely contracted in this way, while experimental efforts were being made to devise some protective inoculation measures.

These yellow fever experiments were sucessfully repeated twelve to fifteen times, and great pains were taken to avoid any possible source of error. It took a great deal of work on the part of the Army Board, under Dr. Walter Reed, to learn the details of the way in which the mosquito conveys the fever. They determined finally, that when a stegomyia that had fed on a yellow fever patient in the first three days of his illness, was made to bite, after ten to fifteen days, a person who had never had the fever, the latter would almost always develope the disease within six days, usually in three or four days.

The manner in which a house may become infected and then disinfected, was also proved by actual experiments directed by the Army Board. The facts are so clearly and simply related by Col. W. C. Gorgas in a pamphlet issued by the Government last year, that I can not refrain from giving them in his own words:

"They built a large room," he says, "and screened it so that mosquitoes could not get in or out. The purpose was, of course, to have a perfectly free circulation of air, but to have the meshes of the wire netting so small that a mosquito could not get through. Then they divided this room into two parts by a wire netting extending from top to bottom, so that a mosquito could not pass from one side to the other, but at the same time leave the circulation of air entirely free, the desire being to show that if it were any miasm, or emanation, or germ floating in the air which caused yellow fever, it could freely pass from one side to the other of this netting, and that both rooms, as far as these emanations were concerned, were in the same condition.

"Now, to show that the building was uninfected, four men were put in it who had never had yellow fever, two sleeping on each side of the wire netting. They were left there for two weeks and remained perfectly well. Reed then said, 'I am now going to infect the room one one side of this wire netting with yellow fever and not infect the other side.' He took the two men out of one side and liberated a half-dozen infected female stegomyia mosquitoes on the same side. The two men still slept and lived on the uninfected side. He then put a volunteer on the side with the mosquitoes and left him there for half an hour, took him out, and within six days this man developed yellow fever, the two men on the other side of the room remaining well.

"He, therefore, argued that, as the two men who had been for so long a time on one side of the wire netting and remained well, were breathing the same emanations, and the only difference was that there were mosquitoes on the infected side, to which the man had been exposed for half an hour, it was very good proof that the mosquito was the factor which gave yellow fever. He then said, 'Now that I have shown you a house infected with yellow fever, I will demonstrate how it can be disinfected and rendered safe.' He caught his half-dozen mosquitoes, bottled them up, put them back into their jars, and announced that the building was entirely safe and uninfected; the two men were put back in the room and all four continued to sleep and live as safely in these quarters as they had before the infection."

Stronger even than this experimental evidence is that furnished by the practical results of its acceptance by the sanitary authorities of Cuba.

It is a matter of history, that notwithstanding the thorough cleaning up given to Havana, during the first two years of American control, the yellow fever situation remained practically unchanged, although health conditions in general were improved. Only after the promulgation of the results of the Army Board experiments, and the adoption of measures suggested thereby, was yellow fever controlled. It decreased rapidly and it is now claimed that no new case of it has developed in the city of Havana since September, 1901, although the percentage of foreign population, consequently of those liable to the disease, has been increasing. This in the face of the fact that no precaution whatsoever is taken, outside of anti-mosquito protection, when a case of the disease is imported, as occurs now and then. While on a visit to Havana, four months ago, the wharf at which such cases are landed, was pointed out to me. It is in the center of the business district, crowded with people, sometimes with several thousand immigrants, who are not immune, yet no preventive measures are resorted to, save seeing that the patient is not bitten by mosquitoes. The litter is screened, and the patient is placed in a screened room at the fever hospital—that is all; still no one has contracted the disease from these imported cases in over three years and a half. Every one in Havana considers it perfectly safe to have the patients come in under those conditions, and it seemed exceedingly significant to me, when I noted how very generally the mosquito theory, as we used to call it, is accepted as being correct by physicians and laymen alike, right in the former hot-bed of disease, where the conditions before and after its acceptance may so easily be compared.

Malaria has at the same time been steadily decreasing in Havana, the number of deaths therefrom having diminished from 325 during 1900, the year before the anti-mosquito campaign was inaugurated, to less than 50 during 1903.

It is scarcely necessary to point out to you the immense advantages to be gained by this community and this section of the country, through the practical extinction of malaria and the elimination of any possibility of yellow fever. While incalculable, they are self-evident, and I shall not insult your intelligence by trying to enumerate them. In order that we may be able to secure them, it is of paramount importance that the public shall have a good understanding of the role of the mosquito in propagating the diseases of which we seek to be rid. Once the necessary information is generally and convincingly spread, the annihilation of mosquitoes is bound to follow. The measures for their destruction are known and practicable; it is not my purpose even to outline them, as they are foreign to the subject of this paper; in order to carry them out sucessfully some intelligence, much patience, and a good deal of money would be required, but the result would more than repay the outlay. With Krumpholz we can say: "The war against malaria costs money, as does all war; but our warfare does not cause misery and death among the victors, our battlefield is transformed into a flowering field in which health and well-being take the place of disaster and poverty." Many other communities have recently accomplished much good by adopting and enforcing proper measures. The City Board of Health, ably led by Dr. Kohnke, have tried earnestly to obtain useful legislation in this regard, but without success so far. Their efforts must be seconded.

If, as aptly has been said, "the physician is the physical guardian of the rising generation," it is the duty of the members of this Society to preach the gospel of the mosquito peril and the crusade for his extermination, for few greater benefits can come to mankind than the extinction of the mosquito. If it is not attained it will have to be ascribed only to ignorance or indifference. I call upon you brethren to take up the good work and to prosecute it vigorously. In addition, I hope I have succeeded in enlisting many missionaries among the rest of my hearers, and that we shall all, laymen and doctors, preach earnestly and labor patiently, persevering until all doubters are convinced and all unbelievers are converted.

Society Proceedings.

Orleans Parish Medical Society.

President, DR. L. G. LEBEUF. *Secretary*, DR. ALLAN EUSTIS.
141 Elk Place, New Orleans.
In charge of the Publication Committee, DR. ALLAN EUSTIS, Chairman
DRS. JULES LAZARD and H. DUPUY.

MEETING MAY 27, 1905.

DR. E. D. FENNER read a paper on

"A Review of Some Recent Literature on the Use of Tuberculin as a Diagnostic Agent, with a Report of Six Cases."

This report was suggested by reading in the *Johns Hopkins Bulletin* for January, 1905, a report on "The Diagnostic Value of Tuberculin in Orthopedic Surgery." As soon as I became interested in the matter, I was surprised to find how numerous were the reports, and how unanimous the commendation of this aid to diagnosis by all who had used it. From personal experience I knew absolutely nothing about it. I knew, of course, in a general way, that tuberculin was used to confirm a suspicion of tuberculosis, but I have never used it and have never seen it used. I take it that most of you find yourselves in the same position, since I think I may safely regard myself as a representative of the ordinary practitioner in this section of the country.

Matters of this kind are brought home to us by the testimony of those we know. It seemed to me then, that a personal test of this method, in such cases as I could get a chance at, would be of value not only to myself, but to others of you here whose attention might thus be drawn to a means of clearing up a diagnosis of many a doubtful and troublesome case, relieving your anxiety as to possible tuberculosis in some, and throwing a brilliant light upon the nature of the case and the indications for treatment in others.

The importance of early diagnosis in tubercular bone and joint cases, is apparent to us all. The whole prognosis, both as regards recovery and deformity, is influenced by the promptness with which the true condition is recognized. And yet these are the very cases in which early diagnosis is often most difficult. The text-book picture of the diagnostic symptoms of early Pott's or hip disease, may seem very clear, but the more experience we have the better we know how hard it is to be sure of the real nature of these cases—whether they are tubercular, rheumatic or hysterical.

I shall not burden you with any historical account of the discovery and use of tuberculin, but shall at once give you a brief resumé of the conclusion drawn by several observers as to the method of using, and the effects of tuberculin as a diagnostic agent.

These conclusions group themselves under:

1. The preparation and dosage of tuberculin.
2. Is its use attended by any immediate or remote danger?
3. The reaction.
4. Is the reaction specific, or does it occur in non-tubercular subjects; and does it always occur in tuberculosis?

J. V. Reed, in the *Journal of A. M. A.*, Feb. 4, 1905, reports on the use of tuberculin to determine the presence vel non of tuberculosis amongst the inmates of a large prison—965 men were examined, of whom 24 had definite tuberculosis and were not tested; 278 gave one or more signs indicating the possibility of tubercular infection, and were submitted to the tuberculin test. Of these, 102 gave a definite reaction, and their subsequent history indicated a correctness of the diagnosis. The dose used was 10 mgms. and the preparation employed was Mulford's purified tuberculin for human practice. No ill effects were noted in any of the 278 cases tested.

Martin and Robbin, *British Med. Jl.*, Feb. 5, 1898, say: "Certainly it cannot be said that any recent observers in injecting five mgms. or less of tuberculin, have ever had either results attributable directly or indirectly to the injection.

"In several cases of slowly resolving pneumonia, where there was evidence of consolidation, and just such a condition as might be incident of tuberculosis, the failure of a reaction to tuberculin rendered the prognosis favorable and was confirmed by the subsequent history.

"In a case of pyuria, in which tuberculosis seemed undoubted, but the reaction to tuberculin was negative, an operation revealed a simple calculus and was followed by complete recovery."

Franklin S. White, in the *Boston Medical and Surgical Journal,* August 5, 1897, reports his results in 123 cases. Forty-five were tubercular, 8 doubtful, 70 presented no clinical manifestations, 66 reacted. The dose he used was 10 milligrams. He regards the agent as not always a specific diagnostic agent.

J. D. Madison, in *Medical News,* May 29, 1897, calls attention to the fact that we still use chloroform and ether in diagnosis, in spite of their well known danger, and he goes on to say that the importance of early diagnosis in tuberculosis would certainly justify the use of tuberculin, even though it were attended by some danger. His conclusions, from his experience, are:

1. Non-tubercular cases may react.
2. Completely healed cases may react.
3. Proved tuberculosis may not react, even to maximum doses.
4. Evidence is conclusive that other diseases, e. g., syphilis, may react; but he believes the percentage of error is less than ten.
5. The maximum adult dose should be more than four, but not more than ten milligrams. The initial does should be 3 to 5 milligrams, followed by the maximum, if necessary.
6. The temperature should be normal at the time of injection.
7. The tuberculin should be fresh.
8. Though there is some danger, it is very slight.

The whole subject is pretty fully reviewed in the article by Tinker, in the *Johns Hopkins Bulletin,* and in the more recent report of Baer and Kennard, in the *Johns Hopkins Bulletin* for 1905. The latter authors record 40 cases of surgery in which tuberculin was used for diagnosis. "Most of them were selected, because the diagnosis needed to be cleared up." Twenty-five gave a positive reaction; 19 did not respond. Of the 25, 6 were proved to be tubercular by operation. Eighteen were confirmed by the subsequent history, and one is still too recent to be considered settled. Of the 15 which did not react, one was operated and no tubercular lesion was found; eight recovered on non-tubercular treatment and the remainder (6) are improved, and all suspicion of tuberculosis has been cleared up.

Baer and Kennard used the tuberculin made by Dr. Trudeau of Sarenac, but this cannot be obtained in New Orleans.

They observed that too small a dose may give no reaction in incipient cases, while too large a dose may cause a reaction even in healthy subjects (Koch stated that ten milligrams might do this.) They advised, in a small child, that the initial dose should be from one-half to one and a half mgms., followed, if negative, by 2 to 4 mgms., after 2 to 4 days, and this if negative, by 4 to 6 mgms. after 2 to 4 days.

A positive reaction is shown by a rise of temperature of at least two degrees or more within 24 hours, the febrile reaction lasting from 12 to 24 hours. The fever is accompanied by general symptoms—headache, anorexia, nausea, occasional vomiting, restlessness, etc. In addition the local signs are increased. In joint cases these are markedly increased, viz., the deformity, muscular spasm, interference with mobility, pain, tenderness and local temperature.

After seeing the active reaction to the injection, the first question which presents itself, they say, is: Is tuberculin harmful?

Frankel, Metetal, White, Reed, Latham, Neff, Osler, Klebs, Martin and Robbins, France, Elder, Voges and others unite in saying that it is harmless. The writers themselves have never seen any permanent harm. Others have expressed a fear that it might be dangerous, but they are not supported in these views by any experience that it is.

Too large a dose may result in prolonging the symptoms of the reaction.

Is tuberculin a specific diagnostic agent? Cases of syphilis, leprosy and actinomycosis are said to react. Beck claims that of the cases of syphilis in which he tried tuberculin, all showed reaction; but it is to be remembered that his dosage was large, and that he required a temperature rise of only half a degree. Otis, in 35 cases of syphilis, got 12 per cent of reactions, and he thinks Beck's figures entirely too high. Baer had one case of syphilis which recovered under antisyphilitic treatment, which did not react to 2 and 2 mgms. of tuberculin.

Taking the testimony of many observers, it may be considered that tuberculin is a specific diagnostic agent, since nearly, if not all tubercular cases react, and very few non-tubercular cases respond.

Baer and Kennard draw the following conclusions:

1. Tuberculin is the best and most reliable agent in the diagnosing incipient bone and joint tuberculosis.
2. Proper administration is without danger.
3. The dose varies; but six mgms. is the maximum.
4. Local signs in bone and joint cases are as important as the general symptoms.
5. Tuberculosis practically always reacts.
6. Other diseases may occasionally react.
7. Diagnosis can be made earlier and more certainly by tuberculin than by the X-ray.
8. It is applicable in private and dispensary cases, as well as in hospital subjects.

Now, in regard to the practical application of this method, the preparation and the dosage of tuberculin, I have purposely left the summary of this to the last.

Koch's original tuberculin is the form advised by all. This may be obtained, I am told, from Victor Koechl & Co., in New York, or Mulford's Purified Tuberculin for human practice, which is the preparation which I have used, may be obtained from their agents in this city.

For young children the initial dose may vary from one-half to one and a half milligrams, according to age. It appears to me that in most of my cases I used an unnecessarily large dose, and that the violence of the reaction was perhaps the result of this. In future cases I shall administer the smaller doses recommended. If no reaction follows upon the first injection, a second, of from 2 to 4 mgms. may be given in from 2 to 4 days. This, if negative, to be followed, after a like interval, by a third injection of from 4 to 6 mgms. In adults the dose should be somewhat larger, the average initial dose being about 2 mgms., increased for second and third injections, as in the case of children. The tuberculin should be freely diluted with one-half of 1% carbolic solution, and this diluted solution should be prepared fresh for each injection. The injection should be made deep into the muscular tissue and for this the deltoid offers a convenient location. Since the rise of temperature is not to be expected for 8 or 10 hours, the evening is the most convenient time for giving it.

A two-hour temperature chart by day and a four-hour record by night, should be kept for at least 24 hours before the injection. Undoubtedly it would be better that the test should be applied in cases free of fever, but moderate elevations may be disregarded, provided their occurrence is known. Inasmuch as fever is not characteristic of incipient tubercular cases, the majority of the patients in whom this method would be applied, would not present a febrile chart before the injection.

Case 1. J. D. C., white, 25 months old, was admitted to the Charity Hospital, Jan 4, 1905, with the following history:

On July 15, 1904, the child had a very severe fall backwards out of his brother's arms. At the time he did not appear to have been much hurt, but two hours later, 7 p. m., his mother noticed that he had some fever, which rose during the night as high as 103° F. The next morning, July 16, he had temperature at 103½° F. He did not complain of his back and walked during the afternoon, but after this refused to try to walk. About a week after the injury it was discovered that the 12th rib on the right side had been broken, a lump being detected "where it was beginning to knit." His knee had been hurt and he suffered a great deal of pain in the left knee. An abscess developed and was lanced by his physician about the middle of August. After about three weeks, the abscess stopped discharging, and for about three months he walked and was apparently perfectly well. About Nov. 20th. the abscess reformed. It was poulticed and broke, discharging for about two weeks, when it closed. Since that time he has been unable to walk.

When brought to the hospital, on January 4, 1905, he was seen by one of the House Officers, and a diagnosis of probable hip disease made, and chloroform given to facilitate examination and the application of a plaster spica. When under the anesthesia, a mass was detected in the left pelvis, which the mother states the doctor called "a bony formation." The application of the spica was abandoned and the X-ray was advised, with the idea that the tumor might be sarcomatous.

It was several days later when I first examined the case. The condition was as follows: The child was well nourished, but was very fretful and rather hard to manage. He could not be induced to stand up. His left hip was considerably flexed and could not be straightened. Flexion was, however, not limited, and rotation was perfectly free. On examining the flexibility of the spinal column, there was very evident fixation of the lower lumbar segment, but no prominence or irregularity of contour. I had been told nothing, at that time, of the pelvic tumor which had been discovered, and taking the physical signs, in conjunction with the history of restless and disturbed sleep and the inability to stand or walk, I made a diagnosis of early Pott's disease of the lower lumbar region. A plaster cast was applied and appeared to give a great deal of relief.

The Family History was in favor of a diagnosis of tuberculosis. His maternal grandmother, and one aunt on the mother's side, died of consumption, at 29 and 20 years, respectively; on the *Father's* side, there was no history of tuberculosis. Five other children, ranging from 4½ to 16 years, are all robust and healthy.

In April, 1904, the child had a pretty severe attack of measles, during which he suffered a great deal with his bowels. But he appeared to have entirely recovered long before he had the fall.

After watching him for several weeks, I decided to try the tuberculin test, and after keeping a record of the temperature from Feb. 8 to Feb. 20, I succeeded in getting some tuberculin from Mulford & Co., and at 10 a. m. Feb. 20 I injected 1½ mgms. into the deltoid region. No reaction whatever occurred, either in temperature or in local symptoms, as the accompanying chart will show. The little fellow was kept in the ward for some time, without any support to the back, the cast having been removed before the injection was given. He seemed to get entirely well, ran about the ward freely, had no pain, and the mass in the pelvis was apparently gone. The proper diagnosis would then appear to be subacute adenitis of pelvis, stimulating Pott's disease.

CASE. II. Louise McIntyre, white, seven years old, was admitted to the Hospital on January 30, suffering from a very large mass of glands in the right cervical region. I am, unfortunately, unable to give a definite statement as to the duration of the trouble or the child's family history. In this case, I left the taking and preserving of data to someone else, with the usual result. However, my distinct impression is that they were of tolerably rapid onset. This I know too, that we all thought them tubercular in character. A two-hour day and four-hour night record was kept of her temperature from Feb. 9 to Feb. 20, which showed occasional rises and some acute exacerbations from 16th to 19th, after which it was normal, or not above 100° F. on one occasion. Suppuration had occurred in the glands, but I determined to use the tuberculin anyhow, Dr. Parham, whose patient she was, having kindly consented. Accordingly, on Feb. 20, 1905, at 10 a. m., three mgms., in 5% solution, was injected into deltoid. No local or general reaction followed. The pus was evacuated the day after the injection and the glands rapidly subsided. On March 6, she was discharged well.

CASE III. Byron Myer, white, age 4 years, was admitted on Feb. 10, 1905, with an inflamed knee. There was a slightly discharging sinus on the inner aspect, where an incision had been made to let out pus. The limb was flexed and painful, and the muscles atrophied, as a result of the arthritis. Here, again, my records have been misplaced, but the trouble was due to a wound inflicted sometime before. The case was not regarded by me as tubercular, but I wished to try the tuberculin test. The usual treatment was instituted for the knee. From Feb. 17 to Feb. 20 temperature was recorded, as in the other cases. It ranged around 100° F., never going above this. At 10 a. m., Feb, 20, 2 mgms. were injected into deltoid. No reaction, either general or local, occurred, and under rest and fixation the small sinus healed, and the child was discharged on April 14, with the knee still rather stiff, but greatly improved.

CASE IV. Viola Gable, colored, age 8 years, was admitted March 15, 1905. She was thin and sickly looking? She had a severe cough of some duration. Examination of the lungs gave distinct evidence of consolidation at right apex of left base. Family history could not be gotten.

The temperature record was kept from March 15 to March 22, ranging frequently below normal and occasionally 99 2-5° F. At 10 a. m., March 22, 1905, about 3 mgms. tuberculin were injected.

At 7 p. m. the temperature had risen to 105° F. She showed very severe general symptoms, and the physical signs in the lungs were much increased. By 9 a. m., March 23, the temperature had dropped to 99½° F. and she seemed relieved of all general symptoms. Later in the day fever rose to 101°, but by 3 a. m., March 25, it was normal. On March 29 she was discharged.

CASE V. Earl Moss, white male, age 8 years, has been a patient in the ward since Jan. 22, 1902. He was admitted with dorso-lumbar Pott's disease. At present he has a large kyphosis and exhibits the typical appearance of an advanced Pott's disease. Being an orphan from one of the asylums, no family history is given. He has not suffered with his back for some time and the question arises whether it is cured or not? Temperature recorded from April 13 to 18, for two days before highest record, is 99½° F. At 4 a. m., April 18, 1½-2 mgms. tuberculin injected into deltoid. The result is shown by the accompanying chart and bedside record.

April 18, 10 a. m., temperature normal; 11 a. m., temperature normal; injection tuberculin; 4 p. m., temperature 103.1-5; 8 p. m., temperature 104; 12 m., 104. Has suffered a great deal with pain in his back, was given tepid bath at 10 p. m.; intense backache during the bath. Slept after bath till 2 a. m. Suffered and moaned all night as if in great pain. Extremely sensitive to touch at seat of disease. No nausea or vomiting all night.

April 19. Highest temperature during the day, 101. Did not suffer any pain, except when touched, when he was very sensitive at seat of disease. Highest temperature during night, 100.4. Rested well and did not complain of any pain.

April 20. Temperature normal during the day, and did not complain. All acute symptoms have subsided.

CASE VI. E. H., white male, age 5 years, was brought to the Out-Clinic at the Charity Hospital, with the following history:

In August, 1904, he had a fall from a little wagon. "His leg has been contracting ever since." In September, his father noticed that the right knee was swollen. During October and November, he had an attack of fever, which resembled malaria. He has not seemed to suffer a great deal of pain in the knee. The family history is negative.

Examination, April 21, 1905, showed a rather characteristic tubercular knee. The leg is flexed at a marked angle. Motion is impaired by muscular spasm and is quite painful. The muscles of the thigh are considerably atrophied. The knee presents a fusiform swelling, especially of the inner condyle. A light plaster bandage was applied in as well corrected position as could be obtained without anesthesia. After about a week, this was removed and a Stromeyer splint applied. Wednesday, April 26, a 2-hour day and 3-hour night record of his temperature was begun and kept up till Friday, April 28. The temperature throughout was normal. At 11 a. m., April 28, 1½ mgms. of tuberculin and 15 minims of normal salt solution were injected into the deltoid. The subsequent record shows: 2 p. m., temperature normal; 4 p. m., 101° F.; 6:30 p. m., 102½°. Cried much about his knee hurting. 8 p. m., 101 3-5° F.; sleeping; 9 p. m., awoke, crying bitterly with his knee. Father rubbed his foot and soothed him to sleep at 9:30. 10 p. m., 102° F. 12 m., 102½°. Sunday, April 30, 2 a. m., 100 2-5°. 4:30 a. m., 99 3-5°. 6:30, 100°. 11 a. m., 98½°. At 1 p. m., temperature was normal, the bandage was removed The limb is rather sensitive, but not painful. Monday, May 1, the child has ceased to suffer, the bandage is still in place. A Thomas knee-brace was ordered, which being finished and fitted in about a week, the child was allowed to return to his home. A letter received on May 10 from the father reports him resting well at night, not suffering during the day, and apparently progressing favorably.

Discussion.

Dr. Simon stated what Dr. Fenner had said regarding surgical tuberculosis was even more strongly manifested in tuberculosis of the lungs. He had seen the tuberculin test tried in a great many cases in the clinics of Germany and he could not recall a single case in which a positive reaction was obtained that did not prove later to be tuberculosis. For the early diagnosis of pulmonary tuberculosis too high a value could not be placed upon the test. Regarding the increase in the local signs in the lungs, he had observed this more or less uniformly, and he had even seen cases in which tubercle bacilli appeared in the sputum during the reaction from the tuberculin test, which could not be found before. In Germany the custom is to begin by injecting as low as one milligram, even to an adult, and if no reaction occurs in 24 hours, wait two days more and then inject three milligrams. If again no reaction is obtained with this dose, five milligrams, or at times as much as ten milligrams, may be given. A high dosage must be avoided in the beginning. There is, however, a danger of starting an acute tuberculosis, more especially in advanced cases, by injecting tuberculin, and this fact must always be borne in mind in using the test. Practically the test should be confined to the early diagnosing, where it has its highest field of usefulness.

Dr. Durel had used tuberculin as a diagnostic agent in a great many cases, and he considered it of the greatest importance. He stated that he had had to refuse admission to his Sanitarium to sixty cases, because the disease had progressed too far for any chance of recovery. He considered that a great number of these cases could have been saved by an early diagnosis. He had seen cases of pleurisy in which there were no definite physical signs, but which, after injection with tuberculin, gave a positive reaction, with more prominent physical signs. The essential point in the treatment of tuberculosis is to diagnose the disease before the tubercles break down. In pulmonary tuberculosis the usual rise of temperature after an injection of tuberculin may be absent, but there is always a local reaction, which is manifested by increased physical signs. He was not in favor of large doses, and stated that repeated injections would give immunity to the reaction. He had never seen any dangers following its use.

Dr. Storck stated that there was no doubt of the value of tuberculin, but that we must not forget the point brought out by Knopf that a latent tuberculosis may be transformed into an active one. It was a question in his mind which cases could be given tuberculin with impunity and which could not.

Dr. Van Wart said that tubercular meningitis always gives definite symptoms, and the use of tuberculin in these cases is unnecessary.

Dr. Bass did not wish to be understood as opposing the use of tuberculin, for he had no personal experience with it, but he wished to state that in Dr. Osler's clinic, in Baltimore, they never used it in pulmonary tuberculosis, although they use it in surgical tuberculosis.

Dr. Fenner, in closing the discussion, stated that he was very much interested in the remarks regarding the use of tuberculin in pulmonary tuberculosis and to note that the physical signs are increased after the injection, and that he had recently been told by Dr. Weis that this phenomenon had not been observed in Boston.

He did not think that the tuberculin test should be condemned simply because one man had used it with a fatal result, when others, after trying it on several hundred patients, had failed to experience any ill effects. If we are able to diagnose Pott's disease before the deformity occurs, he considered that we were justified in employing the test, notwithstanding the few fatalities reported.

Dr. E. D. Martin reported the following case:

"Rupture of the Middle Meningeal Artery in a Boy 13 years of age, produced by a Blow on the Right Temple with a baseball, no grave symptoms for the first twenty-four hours; convulsions and death."

L. B., a white boy, thirteen years of age, while playing ball with some friends was struck on the right temple by a thrown ball, in attempting to steal a base. The blow dazed him for a few minutes and his companions took him to the hydrant and bathed his face. He was soon restored to an apparently normal condition, but about one hour later complained of a headache. He went to a neighboring drugstore and was given a liniment to apply externally. He then returned to his home, and though suffering from a severe headache, continued to play around with his companions and ate some dinner. I was called to see him and reached the house on my first visit at 7:30 p. m. I found no external evidence of injury beyond some edema over the right temple, pupils and temperature normal, pulse 80. I advised that he be sent to bed, that an ice cap be applied over the seat of injury and that he be given a mercurial purge, as his tongue was very much coated. About midnight he complained of nausea, vomited once and purged several times. This condition was attributed to the calomel. His mother states that on awakening the next morning she attempted to arouse him and found it very hard to awaken him. I saw him on my first visit the next morning about 10 o'clock, he was free from headache, pulse and temperature normal, but the right pupil dilated twice the size of the left. I called his father's attention to this symptom, saying that it was necessary that the child should be closely watched, as it probably meant pressure upon the third nerve. His general condition, however, was very good. During the day his mother gave him some cherries, but these he vomited, later he was given some ice cream.

On my second visit at 8 p. m., I found him bright, with normal pulse and temperature and pupils of normal size. His condition was so much better that I felt warranted in saying to his father that I believed he would soon be all right again. At 1:20 a. m., the next morning his mother was awakened by his restlessness; he called to her saying that he had a violent pain in his head and wanted the ice bag which had given him relief before. His mother noticed that his left leg and arm seemed to extend as though he were stretching. She was attracted to this condition by the look on his face. She immediately attempted to get the ice bag, but before it could be filled, he was seized with a violent convulsion, which lasted nearly an hour.

I was called to see him, found him with a pulse of 180, both pupils dilated and breathing stertorous. As soon as I was telephoned to and told his condition, I ordered them to give him an enema of bromide and chloral, which was done at once. At 3:30 his pulse was reduced to 110 and his respirations were less labored. I determined that should his condition improve sufficiently, I would operate, as I was now pretty thoroughly convinced of the diagnosis. I left the house, but was called again at 5 a. m. On reaching his residence, I learned that he was dead and that just before dying a quantity of sanguinous fluid had escaped from his nostrils. At 8 p. m., through the courtesy of Dr. O'Hara and assisted by Dr. W. M. Perkins, I held an autopsy. As soon as the cranium was opened the cause of death was apparent. A large blood clot had formed between the cranium and dura, producing the symptoms which resulted in death; no fracture was apparent. I am inclined to believe that, although the injury to the artery was produced 34 hours before the convulsion, the vessel actually did not rupture until a short time prior to the convulsion, for had it done so the symptoms would have been more pronounced in the beginning and progressed as the hemorrhage increased. This, however, was not the case, for although the right pupil was dilated twelve hours after the injury, it had resumed its normal size twenty-four hours after and all symptoms had apparently subsided.

The case to me is one of extreme interest, showing how serious a comparatively trivial blow may prove. At no time did the symptoms warrant an operation, although I mentioned the possibility to the boy's father when I found the right pupil dilated, but assured him later in the day that all of the symptoms had disappeared and that there was no indication for surgical interference. You can well imagine my surprise and disappointment when I found the child in convulsions, the result undoubtedly of hemorrhage. The condition then was too critical to attempt his removal to the Sanitarium and an operation at that time would have proven fatal.

DISCUSSION.

DR. VAN WART wished to call the attention of the members to one particular sign mentioned by Dr. Martin, *i. e.*, dilatation of one pupil. While in Baltimore, he was able, with the help of Dr. Cushing, to perform an osteoplastic flap on a dog, exposing the entire motor area of the brain. With a small electrode, which they passed over the surface of the brain, they were able to map out the central motor areas for the different muscles. At one time, they obtained dilatation of one pupil, but they had never been able to exactly localize the area. The hemorrhage in Dr. Martin's case was a gradual one, for if it had been sudden there would have been unconsciousness. He stated that Cushing had shown that loss of consciousness in these cases is due to pressure and that venesection is of no benefit, but that craniotomy does seem to help somewhat. He reported one case which had recovered under this treatment.

DR. FENNER did not agree with Dr. Van Wart that the hemorrhage in Dr. Martin's case was a progressive and gradual one. The fact that the boy was seized with pain in the head of sudden onset, followed by convulsions, seemed to him to point conclusively to sudden pressure.

DR. PERKINS also wished to be pardoned for differing with Dr. Van Wart and offered the following explanation of the symptoms: There was probably a slight hemorrhage from laceration of one of the smaller arteries, due to concussion, with the formation of a small clot. There was probably a second severe hemorrhage, which probably would account for the sudden headache and convulsions.

Dr. Dempsey reported a case of dilatation of both pupils, but with complete consciousness, resulting from a fall upon the head.

Dr. Simon remarked that Dr. Martin had not mentioned any symptom of Jacksonian epilepsy developing up to within a short while before death, and for this reason he thought that Dr. Perkins' idea of a secondary hemorrhage was right.

Dr. Van Wart, replying to Dr. Simon, stated that symptoms of Jacksonian epilepsy, as a rule, follow sudden hemorrhage, and not gradual hemorrhage. He considered the final epileptic convulsions in Dr. Martin's case to be due to increased intracranial pressure, probably diffuse.

Dr. Perkins reported a case of Dr. Parham's, in which the hemorrhage was identical as that of Dr. Martin's case, but in which the symptoms appeared suddenly.

Dr. Martin, in closing the discussion, said that he felt convinced that no hemorrhage had occurred at the time of the injury, but that the artery had ruptured just before the convulsions occurred. The observations of the mother would prove what Dr. Van Wart had said in regard to hemorrhage, that is, that the symptoms came on suddenly, producing a form of Jacksonian epilepsy. He thanked Dr. Van Wart for his lucid description and felt sure that his explanation was correct. The case was unusual and he had therefore reported it.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D

A Progressive Parish Board of Health.

We have just received a little pamphlet entitled "Health Hints," which has been recently issued by the Bossier Parish Board of Health for free distribution through their parish. It is neatly gotten up, and includes instruction for the guidance of the people in preventing malaria, typhoid fever and tuberculosis, as well as some hints and instructions concerning general sanitation.

The President of the Board and Health Officer of the Parish is Dr. H. H. Barnacastle, while the other members are Dr. R. B. Martin, and Mr. J. T. McDade.

This booklet could well serve as a model for other parish health boards, and seems to us to be calculated to do a great deal of good. Education of the masses by the physicians and the Health Boards is, after all, what will count most in the fight against disease and death. We congratulate the President and the Board on the progressive spirit shown, and hope others will follow the good example and display equal energy in the good cause.

Prepare for Toy Pistol Wounds.

Notwithstanding the hot weather, the small boy is patriotic enough to celebrate the national holiday with noise; or, at any rate, he is quick enough to seize the opportunity of giving vent to some of his energy yet pent-up at the beginning of vacation.

Soon then will the boom of the cannon-cracker and the roar of the toy pistol mingle with the rattle and the clang of the trolley car, and combine with factory steam whistles and church bells to render life more worth the living.

As our legislators are too enlightened to prohibit the manufacture and sale of these dangerous, if popular, means of amusement (?); and, as even if they were not, our courts would be too deep to permit a law with that purpose to be classed as constitutional, the public might as well make up its mind to grin and bear it, while the doctors should prepare to deal with the effects of the celebration.

The mortality from wounds produced by giant crackers, and especially by toy pistols, used to be appalling, through blood poisoning and lockjaw. With modern methods it has already considerably lessened, and, with a general adoption of intelligent preventive measures, it may be still further diminished.

It might not be amiss to remind our readers that the three fundamental points in guarding little patients against the dangers to which their youthful enthusiasm has laid them open, are: 1, proper mechanical cleansing and drainage of wounds; 2, scrupulous asepsis and antisepsis of the dressings; 3, prompt injection of tetanus antitoxin or antitetanic serum. Prevention is better than cure and, as we have not the power to procure true prevention, we must at least obtain a relative one by eliminating the chief dangers from the wounds once they have been inflicted.

The curative results obtained by the use of tetanus antitoxin have not been brilliant, but for reasons that have been well explained and depend upon the respective time and method of absorption of the poison and the antidote, there is no doubt that the use of preventive injections is almost sure to be satisfactory. As we have no means of determining in which cases there is danger of tetanus, and we know how frequently it accompanies the wounds of which we have spoken, there seems to be only one safe course to pursue: treat all such cases with scrupulous care according to modern surgical technique and resort to early preventive injections of antitetanic serum.

Some Sanitary Needs of a Modern City.

Every now and then a newspaper agitation, or an inspired committee in the city council discusses public baths for New Orleans. As a rule, nothing further results, and the great unwashed of this city go on their uninterrupted way.

Seriously, with the projected improvements in the sewerage and drainage of New Orleans, with the standard of protection which the present Board of Health of the city has established, some move should be made towards a municipal bathing establishment. In New York and other large American cities, provision for public baths has been projected solely for the indigent poor, with no pretensions beyond simple construction and economical supply to this end. In the cities of Europe, however, notably London and Paris, and in Germany, Cologne, Frankfort, Berlin, Dresden; in fact, most every city of reasonable size, there are baths equipped for the service of the entire public. In these a bath may be had for nothing up to a price indicating supreme comfort. At all of these the result indicates that, instead of an annual expense to the city erecting such the bath is, in fact, a source of revenue.

It is only a question of time when the water of the Mississippi will be controlled in New Orleans by the municipality, and such a system for public bathing can be arranged at a minimum cost, and yet, with such style, as to make an establishment of the sort compare favorably with those of European centers. At present, the luxury of a bath is denied the mass of the population, and for these only small provision is made at barber shops or private establishments, where the price is usually greater than the service offered.

We are planning New Orleans as a winter resort. The newspapers discuss avenues of trees and places of amusement to meet the demands of this Nice of the Gulf of Mexico, and yet, the primitive elements of comfort and of sanitary need should not be overlooked.

Our New Volume.

This number of the JOURNAL begins the fifty-eighth volume, and it begins the tenth year of service of the present editors. We are just long enough in harness to grow retrospective, and we may be permitted to say things that others might not say about us. We are prosperous, and he who runs may read this in the pages of the JOURNAL itself, for in these ten years we have almost doubled our reading pages; we have reached after the highest standard for our State profession, and today we represent both the State Society and the local parish societies in our pages. The New Orleans profession has established, through our columns, a representative standing in the country for original research and authoritative opinion, not only upon diseases peculiar to our climate, but in current medical and surgical advance. It is more than gratifying to know that we have contributed to this end.

We are going to keep it up. Our new volume, to follow the announcements of our secular brethren, will present many interesting articles. As heretofore, we shall publish the proceedings of the State Medical Society and of the Orleans Parish Medical Society; we shall present abstracts of the best current medical literature; give news of moment in the medical world and stand for the best standard of ethics and progress.

Every new volume occasions healthy ratiocination, and we are like all editors, we feel the burden of responsibility and know that those who have gone before us have essayed the same problems with varying results. We want our readers to help us, write for us, encourage us, criticise us kindly, and above all believe with us, that this journal is the journal of the profession of which we, as well as they, are a part.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER, New Orleans

A NEW OPERATION FOR THE CURE OF VAGINAL CYSTOCELE.—Ernest Hey. Groves (*Jour. Obst. and Gyn. Brit. Empire, Mar.,* 1905.), describes a new operation for cystocele as follows:

A transverse incision is made from one labium majus to the other about 3 c. m. behind the urethral orifice. The incision divides the whole thickness of the vagina.

The two margins of this incision are then retracted upwards and downwards, and with the finger or handle of a scalpel the urethra and bladder in front are separated from the vagina behind. The margins of the levatores ani muscles are then sought for and defined in either angle of the wound. It will be found that they can be easily brought into apposition with little or no tension. Two or three mattress sutures are then passed right through both muscles as far from their margin as can be done without undue tension, and tied on the outer surface of one or other. These will lie about 1.5 c. m. from the margins of the muscle, which are then united by fine interrupted sutures.

This forms a medium muscular mass about 2 c. m. long and 1.5 c. m. thick, lying beneath and supporting the base of the bladder. The margins of the original incision are now united by catgut, after any redundant vaginal mucous membrane has been removed. The cicatrix lies in a very superficial position—where a little gauze packing serves to keep the wound clean.

THE EMPLOYMENT OF BOSSI'S DILATOR.—Bossi (Zentralbat *für Gynäkol,* 1905 No. 7,) presents a large series of cases collected from clinics outside of Italy, where the employment of his dilator has been used for accouchement forcé. The reports come principally from Prague, Vienna, Berlin, Dresden and Copenhagen, to which he adds sixty-two unpublished cases of his own. In every instance the operation was successful and no deaths occurred. The average duration of delivery was twenty-four minutes. The latest model of his instrument weighs 576 grammes. It is easily taken to pieces and sterilized.

SEVENTY-FOUR CASES OF EXTRA UTERINE PREGNANCY.—Dr. Barton Cooke Hirst reported to the College of Physicians of Philadelphia, seventy-four cases illustrating well known facts in this condition. There was a repeated ectopic gestation, at an interval of five years, a coincident extra and intra uterine pregnancy, an overlooked tubal gestation advanced to four months, and operated on a year after fetal death. The large majority of the cases showed tubal abortion, and those in which there was so-called rupture, on careful examination. showed the features of erosion of the tubal wall of the syncytium, and not laceration of the walls of an over-distended tube. In cases of tubal abortion, the ovum was imbedded usually in a plication of the tubal mucosa; in cases of erosion or perforation the implantation of the ovum was found either at the base of the plication, or in the isthmus of the tube, where the plications lose their prominence. The value of the characteristic pain in the diagnosis of ectopic gestation was emphasized.—*American Journal of Obstetrics,* April, 1905.

PERITONEAL SUTURE AFTER VAGINAL EXTIRPATION OF THE UTERUS.—Schultze (*Monalsschr. f. Geb. a. Gyn.* March,) advocates the closure, by suture, of the peritoneum and vaginal vault, after total extirpation of the uterus, by way of the vagina. He cites many cases, operated on by many excellent surgeons, in which the patient has been lost by prolapse of the abdominal organs, when drainage by either gauze or rubber drainage tubes has been used. The dangers of drainage he gives thus: prolapse of omentum of the intestines, ileo-vaginal fistula, decubitus of the intestines or bladder with adhesions, ascending infection, ileus. All these may be avoided by the author's method of suture, which he has used successfully in fifty-six cases. After unhappy experiences from drainage in hospital work, he adopted in his private practice the simple method of suturing the peritoneal surfaces in the anterior and posterior culs-de-sac and the stump, so as to make a complete closure of the vaginal vault. The serous surfaces are brought into contact, and the supravaginal space is much narrowed. Among the fifty-six cases, there were only four deaths, three of them from in cases of cancer, one of myoma after a recent pregnancy with much loss of blood. One died of pneumonia, two of pulmonary embolism, one of general sepsis; hence deaths were not due to faulty technique in the operation. No hemorrhages followed, and no reopening was needed. The operation takes from half an hour to an hour.—*Amer. Jour. Obstet.,* May, 1905.

Department of General Medicine.

In charge of **Dr. E. M. Dupaquier**, New Orleans.

The Diagnosis of Pleural Effusions in the Aged.—Everybody knows it is far from easy. In positive cases demonstrated by aspiration, the usual physical signs are so altered or so little marked, if at all present, that pleural effusion, as marked in ordinary or classical picture, might be eliminated in the process of diagnosis. In one case reported here, the bronchial souffle and egophony were absent. The vesicular murmur was only diminished, the vocal fremitus and vibrations were still present, though diminished. In another case reported here, while the signs of pleurisy with effusion were characteristic, yet in the large amount of fluid aspirated (1600 and 1200 grammes in two consecutive aspirations), a sign of great value was absent, viz.: Instead of being *abolished,* the vibrations persisted.

Everybody knows that the persistence of the vesicular murmur, and of the local fremitus is commonly found in pleural effusions in children. In old people, this fact does not seem to have been so commonly noticed, and, at the present time, we read yet in the classics, that: "the stethoscopsic signs of pleurisy in the old, are like those of pleurisy in the adult," which is not always the case. The fact referred to might be explained by lesions of the lung, noted in all aged subjects, *without exceptions,* adhesions, etc.—*Revue Méd. de Normandie—Gaz. des Hopitaux* (Halepré et Chevallier) 4 Avril, 1905.

EMPYEMA.—Pus is not uncommonly sacculated; such collections are found posteriorly at any point below the spine of the scapula, in the axillary, subaxillary, and mammary region. Sacculated pus is practically never found above the second rib. Under no circumstance depend on clinical pictures of text-books, on local physical signs or on the general symptomatology. The deviations from the type are those puzzling cases we see in fracture; in the instance, when empyema is simply a possibility, depend on exploration with the needle. Interlobular and mediastinal pus is often inaccessible. Then, when pus is located it is not all. The nature of that pus must be determined. Get a sterile test tube ready and collect some of the pus. Then have it examined to be guided in prognosis and treatment. As a rule, pneumococcic pus is the least dangerous, streptococcic pus is dangerous, staphylococcic pus is equally dangerous. Fetid pus is due to anaerobics. The purulent pleurisy of pure tubercle type is often insidious. Effusion becomes cloudy, but gradually; fever starts and cachexia begins. Course is slow. (Med. Diagn. Hollis & Pedersen.)—*Journal de Med. Interne,* Professeur Hutinel, April, 1905.

TUBERCULIN TEST.—The old tuberculin is better for the purpose. Fresh preparation must be made each time it is administered, that is, the solution or dilution of the tuberculin. In adults, tuberculosis can not be positively excluded, unless up to seven milligrams have been given without producing the characteristic reaction. More than ten milligrams should never be given. (Tuberculosis and Acute General Tuberculosis. Prof. Cornet. Am. Ed. Nothnagel's Practice.)

Department of Ear, Nose and Throat.

In charge of A. W. DeRoaldes, M. D., and Gordon King, M. D.,
New Orleans.

Nasal Aprosexia Associated with Stammering and Empyema of the Maxillary Antra.—G. Hudson Maknen, who has made a special study of the pathology and treatment of stammering, reports a very interesting case of a boy, fifteen years of age, who was affected with a double maxillary empyema, and who not only stammered badly, but was a victim of aprosexia. That aprosexia, or the inability to do intellectual work, is frequently due to nasal obsruction and catarrh in children, is a well recognized fact, and the author considers that in his patient the aprosexia, as well as the stammering, was largely due to the antral affection, a condition unusual at this age. The intimate vascular and lymphatic relations between the nasal and cranial cavities are supposed to account for the evident influence of certain nasal diseases upon the intellectual activity. Maknen finds that in almost all cases of stammering, and allied disorders of speech, aprosexia is present, and concludes that nasal disease is a probable causal factor, therefore, of the speech defects.

Syphilitic Paralysis.—Fournier's analysis of 112 cases of syphilitic paralysis deduces the following:

1°. General paralysis is unknown in the first two years of syphilis.

2. The most precocious manifestation was in the 3rd year.

3. It is rare before the 6th year.

4. The frequency is greatest from the 6th to the 12th year; with the maximum in the 10th year.

5. From the 13th to the 20th year, it is progressively less frequent.

6. In the 20th year it is exceptionally rare.

Rev. Pratique des Med. Cutan. etc., May, 1905.

Louisiana State Medical Society Notes.

In charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr. J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First St., New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist., Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. District, Sunset.

Committees Appointed.

The President has appointed the following standing committees for 1905:

On Scientific Work.—Dr. P. L. Thibaut, ex-officio chairman; Drs. Charles Chassaignac, H. S. Cocram and Isadore Dyer, New Orleans.

On Public Policy and Legislation.—Dr. Henry Dickson Bruns, chairman, New Orleans; Drs. Charles McVea, Baton Rouge, and E. O. Powers, Grangeville.

On Publication.—Dr. P. L. Thibaut, ex-officio chairman; Drs. H. B. Gessner and E. M. Dupaquier, New Orleans.

The appointment of the chairman of sections and openers of discussion will be made in a few days, and announced in the next issue of the Journal.

Parish Society Chartered.

Union Parish Medical Society.—Organized, September, 1904. Chartered, June 15, 1905. President, Dr. C. H. Jameson, Farmerville; Vice President, Dr. Wm. Sellers, Junction City, Ark.; Secretary-Treasurer, Dr. R. L. Love, Farmerville. Other charter members are: Drs. G. B. Smith, Shiloh; J. G. Taylor, Farmerville; J. B. Garland, Bernice; J. G. Evans, Farmerville; P. A. Tatum, Cherry Ridge; O. H. Thompson, Manion.

Election of Officers.—Vernon Parish Medical Society elected the following officers for 1905: President, Dr. F. P. Jones, Leesville; Vice President, Dr. J. D. Tuten, Barham; Secretary, Dr. F. W. Dortch, De Ridder; Treasurer, Dr. J. H. Word, Leesville.

COMMITTEE OF ARRANGEMENTS, 1905 MEETING LOUISIANA STATE MEDICAL SOCIETY.

The men who made the meeting a success.

1. Dr. W. M. Perkins, Chairman. 2. Dr. A. G. Friedrichs. 3. Dr. E. J. Graner. 4. Dr. M. J. Magruder. 5. Dr. A. Jacoby. 6. Dr. J. F. Oechsner. 7. Dr. P. L. Thibaut.

PROCEEDINGS OF THE TWENTY-SIXTH ANNUAL MEETING OF THE LOUISIANA STATE MEDICAL SOCIETY, HELD AT THE MEDICAL DEPARTMENT, TULANE UNIVERSITY, NEW ORLEANS, MAY 9, 10, 11, 1905.

FIRST DAY.—Tuesday, May 9—Morning Session, 9:30.

Meeting called to order by the President, Dr. Charles Chassaignac at 9:30.

THE INVOCATION was offered by REV. DR. JOHN C. BARR.

THE ADDRESS OF WELCOME was delivered by Dr. L. G. LEBEUF, President of the Orleans Parish Medical Society:

I am sorry that I am not able to welcome you more fittingly than this, and I hope you will pardon this physical short-coming of mine, for the heartiness and warmth of the message of the Orleans Parish Medical Society, which I have the honor to represent has charged me to convey to you.

We want every member of the Louisiana State Society to know that every moment they spend in our city, they are our guests. If there is anything you want, which has not been offered you, or thrown open to you, call for it. Either our special representative and your favorite friend and good fellow, Dr. W. M. Perkins, with his committee of arrangement, is here to make things easy for you, or the chairman as well as all the officers or members of the Society are here to serve you in any way you may command. The chairman of the arrangement committee will tell you of the things he has already arranged for your body comfort, and I merely want to report that my entire membership will cheerfully assist him in this pleasant task. I want you to remember that we now own our Domicile, with library and permanent home, at the corner of Elk Place and Cleveland avenue, just two or three blocks from here, and we would be very pleased to have you to make our rooms your headquarters. It is your headquarters also, as you are tenants of the Orleans Parish Medical Society—I have not the right to tender you the keys of the city—but if you are the same old boys of twenty years ago, whom I knew when I was a student at the "Old Charity," I expect you can find those keys easily enough.

In all seriousness though, I am very glad to be present again, I believe, at my 14th attendance of these annual meetings, because each one of these has taught me something new, not only in medicine, but also has seemed to cement the friendships and the good fellowship begun long ago. Our work as hygienists or as consistent apostles of the great laws of prophylaxis and prevention is almost a sacred one, and we can do more good and exert greater influence by acting together and by working as a unit.

It is as humanitarians that our task is at its best, and it is on this line that our best efforts should be exerted. Let us hope that this meeting will erect its stone to that monument, and that we will all help to this greater and higher aim.

DR. WILLIAM M. PERKINS, CHAIRMAN OF THE COMMITTEE ON ARRANGEMENTS, then read the report of that committee.

NEW ORLEANS, La., May 9, 1905.

To the Officers and Members of the Louisiana State Medical Society:

GENTLEMEN: The complete report of the Committee on Arrangement will this year be rendered to the Orleans Parish Medical Society, as under the new Constitution the Arrangement Committee is composed of and managed by that body. As that Society has elected me Chairman it is my pleasant duty to announce that buffet lunches have been arranged to follow the morning sessions each day of the meeting, and that a banquet will be tendered by the Orleans Parish Society to the visiting members of the State Society at the close of the last day of the session.

Cards and invitations to these four functions will be handed to each visiting member as he registers, together with a copy of the program prepared by the Secretary, Dr. P. L. Thibaut, and the badge this year, which is a souvenir pin presented by the President, Dr. Charles Chassaignac.

Provisions for your comfort and convenience have been made and the Chairman of this Committee or any member of the Orleans Parish Medical Society will take pleasure in assisting you in any way possible.

Five subcommittees and the officers of the State Society residing in New Orleans, together with the President and Secretary of the Orleans Parish Medical Society, have worked together as the Arrangement Committee. Railroad arrangements have been in charge of Dr. M. J. Magruder, city; Registration in charge of Dr.

E. J. Graner; Exhibits, Dr. A. Jacoby; Reception, Dr. Allan Eustis, and last, chronologically only, the annual banquet in full charge of Dr. John F. Oechsner.

Respectfully submitted,
WILLIAM M. PERKINS, M.D.,
Chairman Arrangement Committee.

On motion the report was accepted.

Roll call was dispensed with.

The reading of the minutes of the last meeting, 1904, was dispensed with.

Reports of Officers.

THE PRESIDENT, DR. CHARLES CHASSAIGNAC, then read his report.

NEW ORLEANS, La., May 9, 1905.

To the Officers and Members of the Louisiana State Medical Society, New Orleans, La:

GENTLEMEN: It was to be feared that after the boom experienced by this Society last year, for which so much credit is due my predecessor in office and the rest of the previous administration, a certain degree of reaction would follow and that the Society would with difficulty make a showing this year which would compare with that of last year. I am happy to report, however, that, although one or two Parishes which were counted as properly organized and incorporated at the 1904 meeting have failed to keep their interest alive, we have succeeded this term in chartering additional component societies in seven Parishes, including Tensas, Rapides, Catahoula, Concordia, De Soto, Grant and Caldwell. This would now leave barely a dozen Parishes not properly organized, of which about half have such comparatively small and scattered populations that it would scarcely be practicable to get them in line for some time to come.

When we can add that both the nominal membership and the actual paid up membership have increased to a gratifying extent it seems to me that we should feel encouraged at the result, and that persevering efforts will see before long the entire profession of the State in a compact organization. I am not attempting to give exact figures, as these will be shown fully in the reports of your Secretary and your Treasurer.

It gives me great pleasure to say, however, that as far as we have been able to determine the utmost good feeling has prevailed. There have been no bickerings among the members of the profession, the spirit of harmony so necessary to efficient organization having continued throughout.

Our attempt to obtain from the Legislature some changes in the "Medical Practice Act," I regret to say, were not successful. As originally presented the Bill was very carefully and powerfully drawn. After having been somewhat amended, but with the assent of the State Board of Medical Examiners, it was finally passed by the House and lacked only one vote to pass the Senate. The chief difficulty was that we began too late. The same effort on the part of the members of the Board of Medical Examiners, of your Committee on Legislation, and of myself, had they been inaugurated earlier in the session, would have been crowned with success, for, with a larger attendance, we would easily have had a few more senatorial votes. The report of the President of the State Board of Medical Examiners may, perhaps, go more into details on this subject, hence, I shall simply add that I am firmly convinced, if we prepare the ground properly this year, that there is scarcely any chance of failure to obtain satisfactory legislation at the next session, which will take place in 1906.

The Bill which was introduced last year was framed by Mr. Ernest T. Florance, the attorney of the State Board of Medical Examiners. The Board had been requested to have this Bill framed and no arrangement was made with Mr. Florance on the part of this Society as far as I am aware. After the session of the Legislature Mr. Florance handed in a bill for one hundred dollars ($100.00) as compensation for his labors. I did not feel authorized to take any action upon it and merely stated that the matter would be referred to the Society. Hence, I recommend that it be given proper attention, believing that Mr. Florance deserves some substantial recognition for his work, but at the same time that his connection with the State Board and the fact of our failure, while the latter can in no way diminish the value of his services, might lead him to accept a smaller amount than originally demanded.

It became my duty a few months after our last meeting to name a new Secretary owing to the resignation of Dr. I. I. Lemann, who was about to contract new obligations and start on a European tour, hence, I appointed Dr. P. L. Thibaut for the unexpired term. It seemed to me the rational course to pursue, as he had been the second choice of the Society, and I felt satisfied that I could count upon his earnest co-operation.

I wish to express my appreciation of the good work done by Dr. Lemann previous to his resignation, and also of the earnest and efficient collaboration of all the officers of this body, including the Councillors.

Our thanks are due the Committee of Arrangements, who, under the able leadership of its Chairman, Dr. W. M. Perkins, have done everything for our comfort and paved the way for a successful meeting.

The program has been arranged with a view of separating the business from the scientific work as much as possible, and so that both the members reading papers or taking part in discussions, as well as those who are to be only auditors, can calculate easily the time at which they are required or most desire to be present. You will have many interesting and important subjects to discuss, and I trust the session will prove valuable as well as interesting and end by cementing still more firmly the pleasant ties that bind us.

Respectfully submitted,

CHAS. CHASSAIGNAC, M.D.

President.

THE FIRST VICE PRESIDENT, DR. OSCAR DOWLING, then read his report.

Mr. President and Gentlemen of the Louisiana State Medical Society:

May 2 a communication was addressed me in my official capacity by our worthy Assistant Secretary, Mr. Augustin, calling my attention to the fact that I would be expected to read my report on the morning of the first day. In my official capacity I had the honor to sign one warrant for the payment of postage on the Annual Transactions for 1903. The work has been so admirably carried on by our President and the Councillors that they have not needed the services of the First Vice President. The duties of this office during such years as the past makes it a very pleasant one—all honor and no work.

It is pleasant to know that our doctors are laboring harmoniously for the best interest of our organization. Those Parishes in the northern section of the State which seemed derelict, through the efforts of our efficient Councillor, Dr. Norwood K. Vance, have been organized and are doing good work. Through Dr. Vance they have enthused and we may expect far greater results during the coming years. With wide awake officers in each of our Parish societies associated with active members the results of their work will show "the silver lining behind the clouds," reflecting further lustre on this grand organization, making it conspicuous for its good work and thorough organization.

Respectfully submitted,

OSCAR DOWLING, M.D.

The SECOND VICE PRESIDENT, DR. L. C. TARLETON, was absent, and there was no report from him.

THE THIRD VICE PRESIDENT, DR. J. F. BUQUOI, then read his report.

To the President and Members of the Louisiana State Medical Society:

During the past year affiliated Medical Societies in my district have kept pace with the spirit of progress that has characterized our State body since its reorganization on the Parish basis two years ago.

The Second Congressional District comprises the First, Second, Tenth, Eleventh, Twelfth, Thirteenth, Fourteenth, Sixteenth and Seventeenth Wards of Orleans, and the Parishes of Jefferson, St. Charles, St. John and St. James.

Eligible members from the Wards of Orleans included in this District, have been urged to join the Orleans Medical Society. The medical fraternity of Jefferson Parish has likewise been induced to join the Orleans Parish Medical Society, there being an insufficient number of physicians to organize a component Society.

The Bi-Parish Medical Society of St. John and St. Charles has done splendid work during the year. The Society has a total membership of eleven, eight physicians from St. John, and three from St. Charles. No ineligibles.

Meetings are held semi-annually.

This has been found too infrequent to maintain the proper interest among the members, and an effort will be made to meet quarterly.

The St. James Parish Medical Society is one of the most progressive and enthusiastic component societies in the State. Every eligible physician in the Parish, to the number of seventeen, is an active member. Society meets quarterly.

Respectfully Submitted,

J. F. BUQUOI, M.D.

THE REPORT OF THE SECRETARY, DR. P. L. THIBAUT, was then read.

To the Officers and Members of the Louisiana State Medical Society.

GENTLEMEN: In September, 1904, I was appointed by the President, Dr. Chassaignac, to fill the vacancy created by the resignation of your Secretary, Dr. I. I. Lemann.

In submitting this report to you I will endeavor to enumerate the matters of special importance which have presented themselves during the year. Through the medium of our official organ, the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, you have been posted regarding the details of the work of this office, under the heading of "Louisiana State Medical Society Notes."

Since our last meeting we have moved into roomy and comfortable quarters in the Orleans Parish Medical Society Building.

Seven additional Parish Societies have been organized and chartered as component societies, making a total of forty-four Parish Societies, three of which are bi-parish. One other Parish is organized, but has never been chartered, as it has failed to comply with the regulations of the State Society.

Of the forty-seven parishes which have gone into permanent organization only a very small proportion have become lukewarm, and about three are practically defunct. The others have taken a lively interest in organization work, show good attendance at meetings and have furnished us very interesting reports of their scientific and business proceedings.

We have perfected our card index system, which contains the names of the physicians of the State, members and non-members, arranged alphabetically and by Parishes. This index also gives the professional status of all physicians, as far as we have been able to ascertain. In compiling this work we have obtained our information from the reports of the State Board of Health, the reports of Councillors, reports of Parish Society Secretaries and various other sources. This information is not absolutely correct in all cases, but we have every reason to believe that with the perfection of organization in the State, it is only a question of a few years when all such data can be obtained from the office of your Secretary.

We have simplified the vertical file system by arranging all correspondence by Parishes. In addition to this the communications are indexed by name. In this way we have a double check on all correspondence.

No change has been made in the system of vouchers and stubs which had been adopted by your former efficient Secretary, Dr. Wm. M. Perkins. This, with other financial details, will, with your permission, be submitted to the Auditing Committee.

The transactions for 1904 have been published in the official organ, the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL. This mode of publication is a departure from the custom of former years, and we believe has proved more satisfactory, not only by being a saving of expense to the Society, but also by giving wider publicity to the scientific work. In this connection, I wish to thank the editors of the JOURNAL, Drs. Chassaignac and Dyer, for their cooperation.

To the *Medical Recorder* we wish to express our appreciation for the aid it has lent the work of the Society.

I desire to to specially thank the President for his many kind advices, his staunch support and never failing courtesy and consideration.

I have been ably seconded by the Assistant Secretary, Mr. George Augustin, and I wish to extend to him my thanks.

The Chairman of the Committee on Arrangement, Dr. Wm. M. Perkins, has been untiring in his efforts to give you a successful and interesting meeting. His work speaks for itself.

In closing, I wish to also thank the officers and members of the Society for many appreciated courtesies and their constant cooperation.

P. L. THIBAUT, M.D.
Secretary.

The Treasurer, Dr. M. H. McGuire, then read his report.

Gentlemen: My partial report at last year's meeting was completed in July and submitted to the Auditing Committee—appointed for that purpose. My present report commences from that date.

Balance in bank, 7-2-04	$1,861 00	
Deposited in 1904 after that date	128 75	
Total amount carried over from 1904	$1,989 75	
Collected in 1905 for 29 members' 1904 dues	$ 87 00	
Collected in 1905 for 657 members' 1905 dues, less Ex. $1.60	1,969 40	$4,046 15
Total amount to account for	$4,046 15	
Total disbursements for 1905—fees to Journal, salary Assistant Secretary, etc	$2,748 64	
Less amount expended before July report	776 91	
	$1,971 73	1,971 73
Total amount to be accounted for		$2,074 42
Amount in bank May 6	$1,624 42	
Checks in bank for collection	269 00	
Checks and cash in hand	181 00	
	$2,074 42	$2,074 42

Respectfully submitted,

M. H. McGuire, M.D.

Dr. P. L. Thibaut—I move that the report of the Treasurer be referred to an Auditing Committee to be appointed by the President.

The motion was duly seconded, and carried.

The President stated that he would appoint the committee later.

(TO BE CONTINUED.)

Medical News Items.

THE NATIONAL CONFEDERATION OF STATE MEDICAL EXAMINING AND LICENSING BOARDS has postponed the annual meeting set for July 10 at Portland, Oregon. The secretary, Dr. Felix A. Larue, advises us that the meeting will most likely be held during the early winter.

THE NEW ORLEANS COLLEGE OF PHARMACY at a recent meeting adopted resolutions regarding the departure of Walter T. Taylor from his position in the Charity Hospital. Mr. Taylor is now a resident of Los Angeles, Cal.

AT THE LAST SESSION OF THE MISSISSIPPI EXAMINING BOARD there were 187 applicants and only 75 passed.

THIS JOURNAL HAS BEEN HONORED with the third cash prize of $5 given by the Mellier Drug Co., of St. Louis, for the fine appearance of Go-Shono, the Apache Medicine Man, which appeared in the advertising department. The money was presented to the pressman, Mr. Berry, of L. Graham & Co., Ltd.

THE OHIO BOARD OF HEALTH HAS ISSUED INSTRUCTIONS TO SUFFERERS FROM VENEREAL diseases, a supply of which is sent to every physician with a request that he hand one to each of his venereal patients.

THE ONE-HUNDREDTH BIRTHDAY OF DON MANUEL GARCIA, the discoverer of the laryngoscope, who is living in London, has been fitly celebrated by the homage of the scientific and medical worlds.

THE PORTLAND (OREGON) CITY AND COUNTY MEDICAL SOCIETY at a recent meeting decided to give a smoker in honor of the medical visitors to the city in July.

AN ANNOUNCEMENT IS MADE BY THE RUSH MEDICAL COLLEGE THAT IT WILL ADD A FIFTH YEAR to the curriculum, beginning with the session of 1905-1906, which for the present will be optional.

THE POSTOFFICE DEPARTMENT HAS ISSUED A SERIES OF FRAUD ORDERS AGAINST some 50 "female doctors", patent medicine dealers and other individuals of kindred character, who have been doing a prosperous business in Boston and its surroundings for many years.

IN MEMORY OF THE LATE DR. N. S. DAVIS, of Chicago, the American Medical Society for the Study of Alcohol and Other Narcotics, has arranged to hold a memorial meeting at Portland, Oregon, July 11, 1905. An entire evening will be devoted to commemorative addresses and papers on the life of Dr. Davis.

THE NEW ORLEANS POLYCLINIC at its annual meeting in June re-elected Dr. Charles Chassaignac, President, and Dr. P. E. Archinard, Vice President; Dr. C. Jeff Miller was elected Secretary and Treasurer in the place of Dr. Isadore Dyer, who retired after a service of ten years in this office.

A COMMITTEE OF THE FACULTY OF TULANE UNIVERSITY has issued the following obituary:

"Dr. Henry Bristol Orr, whose untimely death on Monday, the 29th of May, after illness and suffering borne with surprising fortitude and cheerfulness, has saddened a wide circle of friends, was for a number of years Professor of Biology in the Tulane University of Louisiana. He was a man singularly gentle and unpretentious, a scholar and a savant that had enjoyed the best training, both general and special, that was offered either in America or in Germany. He was more particularly well-versed in his chosen subject of biology, which he had studied under the great master, Haeckel, at Jena, where he attained his doctorate, and also in the allied subjects of philosophy and experimental psychology.

"He was the author of an interesting volume, entitled '*A Theory of Development and Heredity,*' in which he set forth his views on the great questions of biological science, and which was well received by his fellow-biologists.

"As a colleague he was generally and highly esteemed, and his relations with his co-workers were cordial and pleasant. His notable modesty and his reticence seemed sometimes to stand in the way of a full recognition of his worth. It was a matter of concern and regret to the Tulane faculty that his tastes and his interests were in time diverted from this purely scientific chair toward the kindred profession of medicine, and that he finally relinquished his position in the university in favor of the active practice of his new calling as a physician. Their sympathy, however, and their best wishes remained with him always, and they felt it keenly when the intelligence reached them of his alarming condition. They deplore deeply his sudden taking off in the full noon of his days, and they extend to his bereaved kinsmen the earnest assurance of their lively sense of loss and of their just appreciation of their former colleague as a scholar, as a thinker, as an educator and as a man."

PERSONALS.—Dr. S. M. Lyons, of Vinton, La., has been appointed as a member of the Board of Supervisors of the State University.

Dr. L. A. Mereaux is the new president of the St. Bernard Board of Health.

Dr. and Mrs. A. W. DeRoaldes are enjoying a trip through Europe.

DIED—On Monday, May 29, 1905, at 8:45 p. m., Dr. Henry B. Orr.

Dr. Emmett Jowers, who recently practiced as an oculist in New Orleans, but had since moved to Channing, Texas, on account of ill health, died at that place, at the age of 46 years. The doctor was a native of Preston, Ga.

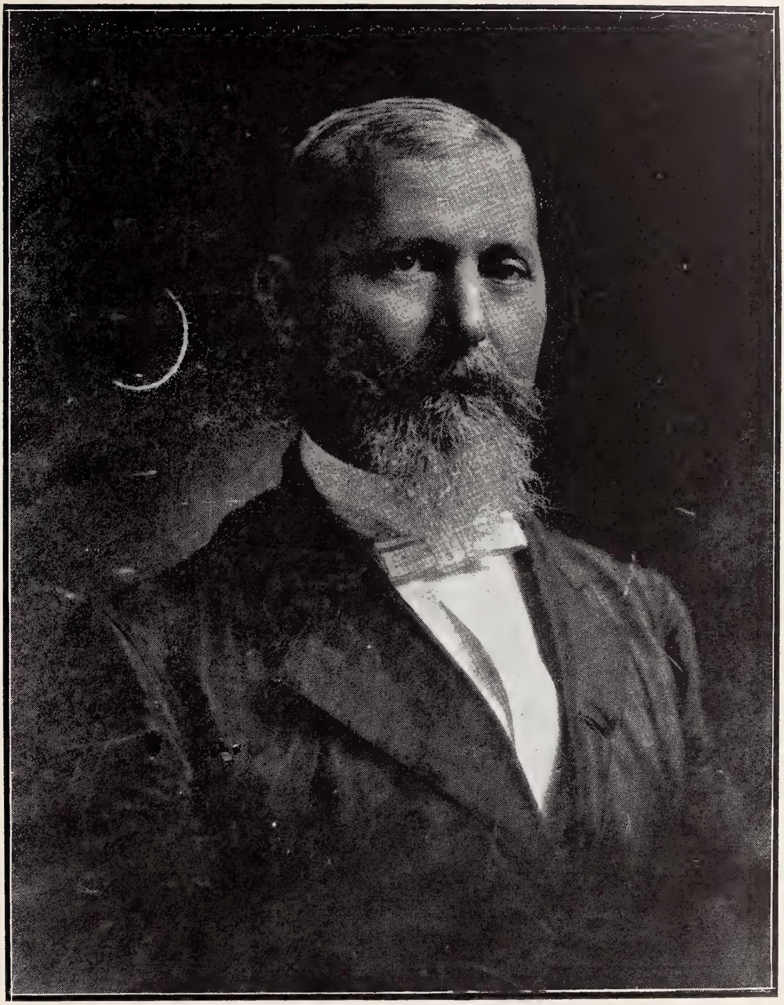
MARRIED—Dr. T. H. Hanson of Donaldsonville, and Mrs. Annie E. Stockwell, at Baton Rouge.

Dr. Espy Williams, of New Orleans, was married to Miss Emily V. Raine. The marriage was celebrated at San Francisco, the home of the bride.

Dr. Emile Ehlert and Miss Alice Louise Dirker, were married June 20, at Trinity Chapel, this city.

THE NEW PRESIDENT—Dr. C. J. Ducoté, who was recently elected president of the Louisiana State Medical Society, and whose portrait we present in this issue, was born November 8, 1849, at Cottonport, Avoyelles Parish, Louisiana; educated at the Louisiana State University, Baton Rouge, and graduated with the degree

New Orleans Medical and Surgical Journal,
July, 1905.



DR. C. J. DUCOTE,

President Louisiana State Medical Society.

of B. A. in 1871. He matriculated at the Medical Department of the University of Louisiana, and subsequently became interne at the Charity Hospital. He obtained his degree of Doctor of Medicine in 1875. He has been actively engaged in practice for over thirty years in his native place. He represented his district in the State Senate, during Governor Heard's administration. He is now a member of the Board of Supervisors of the Louisiana State University, and takes a deep interest in all matters which affect his Alma Mater. He is President of the Cottonport Bank, and is the organizer and President of the Avoyelles Parish Medical Society, which is considered one of the best of the component societies of the State organization.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Practical Pediatrics, by DR. E. GRAETZER. Authorized translation, with numerous additions, by HERMAN B. SHEFFIELD, M.D. F. A. Davis Company, Philadelphia, 1905.

As the translator calls it, this volume is a miniature encyclopedia of medical and surgical diseases of infancy and childhood. Attention is called to the abundance of practical and clinical material, the avoidance of superfluities, and the especial emphasis upon the numerous *deviations* from type which so often baffle the skill of the general practitioner. Additions indicated by brackets have been inserted by the translator, such as sections on intubation, Lorenz's operation, broncho-pneumonia, achondroplasia, home modification of milk, gonorrheal ophthalmia, tinea tonsurans, hydrotherapy, massage and electricity, climatology, palatable prescribing, antitoxin, several newer standard remedies, etc.

DUPAQUIER.

Pneumonia and Pneumococcus Infections, by ROBERT B. PREBLE, A.B., M.D. Cloyd J. Head & Co., Chicago, 1905.

There are but few monographs on pneumonia that can compare with this as to immediate usefulness. Just what the profession wanted for a long time is to get rid of a number of wrong ideas that have burdened us in treatment. The relief that this splendid booklet carries with its teaching is simply life-saving, and boldly should those who read it, now express and propagate sound views that were only stagnating in the stage of formation in their own minds. Should every satellite in his sphere of practice take up the ideas on treatment of such clear-minded leaders as Musser and Preble, for instance, the "good news" would soon become a universal golden rule of practice and surely, we believe, until a true antitoxsin comes, if it can ever come, mortality will be lessened.

DUPAQUIER.

The Modern Mastoid Operation, by FREDERICK WHITNEY, A.M., M.D. P. Blakiston's Sons & Co., New York, publishers.

This excellent work by one of the most able aural surgeons of the day, fills a long felt want in otological literature. The object of the author has been to put before the medical public a complete treatise on the surgery of the mastoid process, beginning with the first attempts made by the early surgeons and ending with a minutely detailed description of the radical mastoid operation as performed today on thoroughly modern principles. The author deals extensively with the pathology of suppurative mastoiditis, the differential diagnosis, the indications for operation, the preparation of the patient, as well as the complete details of technique of the operation and the after treatment. The text, which is clear and concise, is richly illustrated with plates made from original drawings, and the work as a whole represents the best and most complete treatise yet published on this important branch of surgery. DeR. & K.

Diet in Health and Disease, by JULIUS FRIEDENWALD, M.D. W. B. Saunders & Co., Philadelphia, 1904.

"These few rules of diet he that keeps, shall surely find great ease and speedy remedy by it."—Burton.

Works of this kind have a family resemblance, but this is one of the best looking in the family. The subject of alcohol is treated after the teachings of Atwater, and as far as our knowledge goes, these teachings are the most sane and rational so far proved or advanced.

In spite of what Dr. Eccles thinks regarding the value of salicylic acid as a safe food preservative, we believe as the author of the book under review does that "It is undoubtedly highly objectionable, and its use should be prohibited." In respect to Eccles' statement that "as a matter of fact those who object so eloquently to all chemic food preservatives seem to forget that sodium chlorid, acetic acid, and ethyl alcohol are chemicals," I think it can be said in reply that sodium chlorid and acetic acid are food adjuncts of much value, and that sodium chlorid is one of the salts absolutely necessary for the maintenance of life, forming, as it does, about 60 per cent. of the salts of the blood. Now, no such claim has ever been made for salicylic acid, either as a food adjunct, or as a substance possessing food value. As for ethyl alcohol, while we do not sanction its extensive use, still there are those who give it credit for some food value.

We quote under the heading Technic of Modifying Milk at Home: "To insure success in home modification a very careful technic must be followed by the mother or the nurse. In the absence of a nurse specifically trained for the purpose it becomes necessary for the physician to give careful written and verbal instructions, and then to see personally that these are carried out. Knowledge on the part of the mother or nurse should not be assumed, for, as a rule, she does not possess it. There are many nurses, both graduate and otherwise, whose conceptions of infant feeding and milk preparation are practically useless. Like many medical students and recent graduates, they understand more about laparotomies than they do about milk. If this be borne in mind, many unpleasant experiences may be avoided."

On the whole, this work has much to recommend it. STORCK.

Clinical Hematology, Practical Guide to the Examination of the Blood With Reference to Diagnosis, by JOHN C. DACOSTA, JR., M.D. Second edition, revised and enlarged. P. Blakiston's Sons & Co., Philadelphia, 1905.

This work of DaCosta promises to take a front place among works of its kind. The student of hematology will find it a reliable authority on almost everything pertaining to the blood; likewise, the busy practitioner will find it a most excellent guide in everyday routine clinical work, as its descriptions of methods of examination are as explicit as possible. Particular attention is given to those methods of examinations most likely to prove useful in everyday practice.

In regard to Deland's Hematocrit the following appears, to which I think every worker in hematology who has had experience with the instrument will subscribe:

"The hematocrit if its clinical application is limited to the determination simply of the relative volumes of the blood corpuscles and plasm, may be relied upon to furnish, on the whole, dependable information, the necessary errors attending its use being within two per cent. It is also useful in the study of hemoglobinemia, cholemia, and lipemia. If employed in the role of a hemocytometer, however, its results must needs be highly inaccurate, just in those instances in which exact methods of investigation are all important. It is true that in normal blood, in which the size of the corpuscles ranges within the physiological limits, it is correct as representing approximately a count of 100,000 erythrocytes per c. mm. In blood characterized by any considerable deformity in the size and shape of these cells, as in high grade anemia or in leukemia, it is perfectly obvious that no such correspondence between the count and the percentage volume can be expected—blood in which microcytosis is pronounced is certain to show a lower percentage volume of erythrocytes than blood in which megalocytosis prevails, or than blood containing normal-sized cells, although the counts of all three may be identical. Similarly, a given number of lymphocytes should indicate a lower percentage volume than an equal number of myelocytes, or even polynuclear neutrophiles. On account of these sources of fallacy, if for no other reason, the hematocrit estimate should never be taken as a basis for calculating the count in pathological conditions, in lieu of the more accurate, if more laborious, method of counting the corpuscles." STORCK.

Diseases of the Liver, Gall-Bladder and Bile Ducts, by H. D. ROLLESTON, M.A., M.D. W. B. Saunders & Co., Philadelphia, New York, London, 1905.

This work of Rolleston should be welcomed by the English-reading part of our profession, as it is, par excellence, the most valuable addition to English medical literature with which we are acquainted.

Dr. Rolleston's long experience in the study of diseases of the liver, both from the clinical and the pathological points of view, has enabled him to make valuable contributions to our knowledge of the subject by his personal experiences.

No bibliography has been appended, reference being made only to authors actually quoted. The illustrations are excellent, and, for the most part, original.

Under the head of race and geographical distribution of Cholelithiasis we quote the following:

"Gall-stones are rare in warm and tropical countries and are common in cold and damp cities, probably because these conditions tend to induce catarrh of the biliary tract.

"Cholelithiasis is common in Germany, Austria, Sweden, Hungary, Russia, and is said to be infrequent in Holland, Finland, Denmark, and Italy, England probably comes midway between these two groups. In America the percentage incidence is about the same as in England; thus Mosher found it to be 7 per cent. The natives of Indian are remarkably free from gall-stones. Gall-stones are very rare in the negroes, probably from their more active life, and possibly from the good state of their teeth, in virtue of which they would not be exposed to infection of the alimentary canal from pyorrhea alveolaris."

General treatment is considered under the follow heads:

"To Prevent Stagnation of Bile.

"To Prevent the Occurrence of Catarrhal Inflammation of the Gall-Bladder and Bile Ducts.

"To Remove Catarrhal Inflammation When it Has Appeared.

"To Attempt to Dissolve and Remove Calculi from the Gall-Bladder and ducts.

" Spa Treatment." STORCK.

Operative Surgery, 2 Vols., by JOSEPH D. BRYANT, M.D. D. Appleton & Co., New York and London, 1905.

We heartily welcome the appearance of Bryant's 4th edition of that most important branch of medicine—*Operative Surgery.*

One has but to compare this new edition with the preceding (1899) to realize at a glance the large increase of reading matter (250 pages more) and illustrations (230 more).

The work is thorough and up-to-date and needs but commendation.

It is with no small amount of pardonable pride that we read on pages 39, 40 and 41 (Vol. 1), not only the description of Matas's infiltration anesthesia apparatus, but also the endorsement of "its great practical utility."

We, who are reviewing this book, can fully testify to the correctness of the above assertion, having been for several years associated with Prof. Matas.

The method of spinal anesthesia, which caused such a furore a few years ago, and which, as the author aptly says, "may be employed when local anesthesia is impracticable and general anesthesia is contraindicated in operations of magnitude," is clearly described with accompanying illustrations.

Other important advances in surgery are mentioned in Vol. I, viz.: Arteriorrhaphy (Murphy), Radical Cure for Aneurysm (Matas), Crile's Suit for Shock, Thyroidectomy (Kocher), etc.

We are equally pleased to find in Volume II (pages 1273-1274) deserving mention of the weighty opinions of our two eminent local surgeons, Matas and Parham, in reference to the Fell-O'Dwyer apparatus for forced artificial respiration.

This volume contains some new operative suggestions for appendicitis; recent approved measures in the surgery of the prostate, gall-bladder, stomach and intestines, are fully dealt with.

Ureteral Anastamosis and Extroversion of the Bladder, are likewise lengthily dwelt upon. LARUE.

A Treatise on Obstetrics for Students and Practitioners, by EDWARD P. DAVIS, A.M., M.D. Lea Brothers & Co., Philadelphia and New York.

Nine years ago the first edition of this work made its appearance. The present one is almost entirely re-written, and contains about 250 more pages. The same practical method of teaching has been retained.

On comparing the chapters on Eclampsia and Septicemia of this edition with that one of 1896 the great improvement made in the study of these conditions is readily observed.

There is an unusually long, but very instructive, chapter on the Physiology and Pathology of Infancy. MICHINARD.

Publications Received.

LEA BROS. & CO., Philadelphia and New York, 1905.
Acute Contagious Diseases, Welch-Schamberg.
Medical Epitome Series, Clinical Diagnosis, by Dr. R. Arneill.
A Manual of Practical Hygiene, by Dr. Charles Harrington. 3rd Ed.
The Diagnosis of Diseases of Women, by Dr. Palmer Findley. 2nd Ed.

CLOYD J. HEAD & CO., Chicago, 1905.
Maternitas, by Dr. Charles E. Paddock.

A. R. ELLIOTT PUBLISHING CO., New York, N. Y., 1905.
Tumors of the Cerebellum, Mills-Frazier-Schweinitz-Weisenburg-Lodholz.

P. BLAKISTON'S SON & CO., Philadelphia, 1905.
Enlargement of the Prostate, Deaver-Ashhurst.

E. B. TREAT CO., New York, 1905.
Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition, by Dr. Carl von Noorden.

D. APPLETON & CO., New York and London, 1905.
Practical Dietetics, by Dr. W. Gilman Thompson. 3rd Ed.
Infectious Diseases, by Drs. J. C. Wilson and Julius L. Salinger.

MISCELLANEOUS.

Report of the Chief Sanitary Officer of the Canal Zone, February 20, 1905.

Annual Reports of the Department of the Interior—Commissioner of Education. Vol. II.

Reports of the Department of Health of the Isthmian Canal Commission for the months of January, February and March, 1905, by Col. W. C. Gorgas, M.D.

The Monthly Bulletin of the Arkansas Medical Society for the Months of September and October, 1904, and *January,* 1905.

Reprints.

First Aid to the Injured; An Emergency Poisoning Case, by Dr. J. W. Wainwright.

Some Experiments with a New Bacillus in Mixed and Double Infections; Climatic Blood Conditions; A New Lower Jaw Splint, by Dr. Ira B. Bartle.

Prism Exercises—Their Indications and Technique; Congenital Deficiency of Abduction, etc.; The Precise Measurement of the Primary and Secondary Deviation in Paralysis, etc., by Dr. Alexander Duane.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR MAY, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	3	3	6
Intermittent Fever (Malarial Cachexia)	3	2	5
Small Pox	......	1	1
Measles	......	......	......
Scarlet Fever	......	......	......
Whooping Cough	4	2	6
Diphtheria and Croup	1	1	2
Influenza	......	2	2
Cholera Nostras	......	2	2
Pyemia and Septicemia	3	3	6
Tuberculosis	38	54	92
Cancer	22	6	28
Rheumatism and Gout	1	1	2
Diabetes	2	......	2
Alcoholism	1	1	2
Encephalitis and Meningitis	15	4	19
Locomotor Ataxia	2	......	2
Congestion, Hemorrhage and Softening of Brain	21	9	30
Paralysis	1	1	2
Convulsions of Infants	5	3	8
Other Diseases of Infancy	31	20	51
Tetanus	2	8	10
Other Nervous Diseases	1	1	2
Heart Diseases	29	27	56
Bronchitis	1	2	3
Pneumonia and Broncho-Pneumonia	15	21	36
Other Respiratory Diseases	7	4	11
Ulcer of Stomach	......	1	1
Other Diseases of the Stomach	......	......	......
Diarrhea, Dysentery and Enteritis	91	46	137
Hernia, Intestinal Obstruction	2	1	3
Cirrhosis of Liver	7	......	7
Other Diseases of the Liver	1	1	2
Simple Peritonitis	1	1	2
Appendicitis	5	......	5
Bright's Disease	37	19	56
Other Genito-Urinary Diseases	2	5	7
Puerperal Diseases	5	......	5
Senile Debility	14	12	26
Suicide	13	......	13
Injuries	21	17	38
All Other Causes	15	9	24
TOTAL	422	290	712

Still-born Children—White, 25; colored, 16; total, 41.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 21.18; colored, 40.46; total, 26.28.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	29.95
Mean temperature	79.
Total precipitation	4.23 inches.

Prevailing direction of wind, south.

New Orleans
Medical and Surgical
Journal.

VOL. LVIII. AUGUST, 1905. No. 2

Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

The Barber Shop in Society.

By ISADORE DYER, PH. B., M. D.

Associate Professor on Diseases of the Skin, Medical Department,
Tulane University, New Orleans.

There was a time when medicine and surgery were in the barber's debt. The cupping basin still rattles outside the shop of the hairdresser in Holland and in France, even in some English towns. With the "leech" as with the surgeon barber, the advance of civilization demanded a higher order of training, and both drifted into a natural field of occupation, the one becoming the prototype of the modern druggist and the other the hairdresser and modern barber. In almost every trade charlatanism finds its followers, and it is not a far step from the pretension of the counterprescribing druggist to the wheedling barber, both coming by natural inheritance into the practice upon a willing public, ready and fully used to being imposed upon. In almost every country the barber has established himself as a group of types—the most interesting one being the expert upon dermatologic conditions as they affect not only the head, but also the hands and feet. In modern society, with both sexes, the hairdressing establishment has now, a long time, become an essential, and the proprietor has grown to be an adviser regarding not only the care of the hair and skin, but also regarding the relief of diseased conditions. Any well equipped establishment carries not only the implements of the hairdressing trade but, as well, a complete armamentarium in so-called cosmetics, for the scalp, face, hands and feet. The public suffers all these things, and it seems hard to believe that men and women of even large intelligence submit to opinions at the hands of these pretenders to the point of experimenting with any or all of the wares they dispense.

Individual experience from time to time may effectually provoke a reaction, but with the majority of people the evidence is contrariwise. They abandon one establishment only to be successively abused by a series of others more or less pretentious in their claims of merit. The habit of the public has broadened the opportunities of the practician in human gullibility, and the mass of cosmetics for the face and scalp has grown voluminously.

It is a curious fact that whenever a sane movement has started directed at correcting the evils of society, the very public itself has entered opposition, under the apprehension that such a movement contemplates a curtailment to their individual privileges and rights. One wave after another of enlightenment has passed over modern society, and the public has grudgingly permitted legislative acts affecting the control of conditions affecting the public health, and even then they openly encourage the violations of the same law, by patronizing any and all fraudulent institutions which exist solely upon their pretensions and a fresh and gullible public interest.

The barber shop carries such evils in all of its departments. Here and there a more pretentious artisan has separated himself as a chiropodist or manicurist, and plies this end of the business among willing victims who not only submit to the barbarous practices of corn cutting and nail mutilation, but go as far as to use medicines advised by these, to whom they not infrequently apply the title of "doctor," as if they were indeed of the guild.

The average medical man passes over such infringements of his legal rights, not to mention the assumption of professional privileges, and not infrequently even the medical man himself is not careful in avoiding the very patronage of such persons.

The barber is a self-constituted custodian in ordinary of every patron's scalp. He is familiar with each combination of conditions which are together responsible for the alteration in the hair and for each he has a supreme remedy—and if it fails he has another. Among foreign barbers, especially in Latin countries, the most profitable part of their avocation is in the sale of their lotions, face washes, hair dyes, cosmetics, and the like, and the casual or habitual patron of the establishment is beguiled in almost any language with the encomiums upon the worth of each particular cosmetic which may in any way attach to his particular face or head. The man with a mass of hirsute appendage is advised that his hair is too dry or too oily—and when the hair is thin or even departed there are pomades, or, if you prefer, balsamic lotions which promise to put nature to the blush in the rapidity of their action, and even when you have quite finished, the barber bows you out with a suggestion in the way of toilet articles.

These are evils, and evils which might be corrected, only the policeman of society's morals and customs finds very little sympathy. Meantime, the barbers themselves have organized in unions, prescribing the conditions which must regulate their own trade—fixing qualifications in service and in skill—but forgetting entirely that a barber is essentially a workman and not an artist nor a professional man, even if in their articles their trade may be referred to as the "tonsorial profession."

There is another division of interest in the barber shop question which is more vital. The abuse of the ignorance of the public in wheedling them is very small in comparison.

Here are some facts which are well known to every medical man who especially deals with skin diseases:

1°. Fully ninety per cent. of baldness owes its origin to the barber shop, directly or indirectly.

2°. From ten to twenty-five per cent. of the practice of a specialist in skin diseases, comes from barber shop infections and their consequences.

3°. The list of skin affections arising from the barber shop includes some of the worst, and among parasitic diseases there are a large number which the usual barber shop practice may spread.

Baldness is much more general than it was a few years back, and the average man has become indifferent to it. Formerly the wigmaker was often called upon to cover bald spots with the "toupee," while now a man seldom gives the bald spot any consideration.

There are several sorts of baldness, and not all may be laid at the barber's door. Syphilis, parasitic diseases, as well as in indirect nervous affections may each cause baldness. But exactly as the differences among flowers are definite, so are the distinctions in bald heads. Syphilis gives the scalp a moth-eaten appearance on the sides and back of the head. The parasitic diseases destroy the hair only in the immediate areas of their occupancy of the skin, and then the hair is only broken off, while each spot is covered with scales or crusts. The baldness of nerve origin occurs in round patches, running around the borders of the scalp. Tuberculosis may cause baldness, but the presence of the tumors of the disease, or the pitted scars left behind bear witness to the cause.

Dandriff is the only other originating cause of baldness, and is held responsible for 90 per cent. of all bald heads. Pityriasis capitis is the general term employed for scaling of the scalp, and in this generic term are included a number of scaling diseases which may affect the scalp. Not all of these, however, have any action on the hair. Besides the parasitic diseases, which include ringworm and a rarer disease called favus, the pityriasis capitis includes affections of the fat glands, called seborrhea, of which the dry variety, seborrhea sicca, is one—and "dandriff" is a modification of this type. The association of the scaling of the scalp with baldness led to the investigation of a possible parasitic origin. As far back as 1874, Melassez described small spores found, and his observations were later confirmed by Beck, and others.

Unna in 1890, with improved methods discovered a bacillus, called the "flask or bottle bacillus."

Merritt of Boston, in 1895, described two kinds of organisms, of the type of diplococcus, capable of reproducing the same scaling wherever they were planted.

In 1897, Sabouraud elaborately experimented in the matter and succeeded in clearly reproducing the micro-bacillus which he believes responsible for the scaling and the original factor in the baldness consequent upon its presence. The process is described as due to an invasion of the follicles and the separation of the hair with a final influence on the fat gland which supplies the hair. Each hair shaft is supplied with two or more fat glands and when these are interfered with or are destroyed there is a natural atrophy of the hair bulb itself.

Elliot of New York tabulated a large number of cases of baldness which came under his observation in private and hospital practice and demonstrated 90 percent of these to be due to dandriff.

The logical deductions are not difficult. Experiments showed conclusively that on the scalp the organisms develop easily and rapidly and that the scales carry the source of infection—these are readily transferred from the scalp to the eyebrows, to the eyelashes, to the hairy beard, to the hairy chest, the axillae, to the other hairy parts of the body, and that they even develop on other regions of the body which are supplied with fat glands. The term dandriff is the popular name for a specific disease now recognized as seborrheic (referring to the fat gland involvement) dermatitis (or inflammation of the skin).

Premature baldness for years was held a sign of early senility or else the evidence of an hereditary predisposition to hirsutic loss. Even today the bald pate and ascending forehead are explained on these grounds. But study the natural conditions which exist. A virgin scalp is brushed daily with a brush carrying the infection of dandriff, first contracted from some other brush. The brush contracts the disease and each time the head is brushed fresh focuses are established; the disease is rubbed in. The most frequent parts brushed are the top of the scalp, for the average individual brushes hard here, in the search for a parting of the hair.

Among the thousands who frequent the barber shop, how many seek infection from the common brush? Ask the barber himself how many of his patrons refuse to have him use a brush? The man carries the infection home, uses the brush of some other member of his family when his is not convenient; or his brush is employed on the children; even the wife may find his brush better than hers and so the story goes. It is quite common for the mother to brush the head of all the children with a common brush. Once established in the household the disease remains, and it remains until it is destroyed—for even the loss of the weaker hair does not prevent the nesting of the disease in the other hair on the head.

Dandriff, or seborrheic dermatitis, will develop in 72 hours on a healthy scalp! Does this mean anything to the man who is shaved by the barber four or five times a week and who is brushed with a brush used on dozens of heads before him? For the barber is not particular and his brush is usually only washed days apart, seldom even once a day.

Dandriff does not stop with simply destroying a part of the hair on the scalp. The microorganisms which develop this disease are likewise contagious on other parts of the body.

Blear-eyed children, and even adults, try to rub off the cubes of yellow fat and scales which accumulate along the shafts of the eyelashes—only to produce in further turn the inflammation of the lids themselves. The eyebrows are a frequent site of development of dandriff scales and from here across the arch a band of yellowish red patches form, often running down over the nose and on either side. The ears may derive infection and often serious complications follow the invasion of the ear canal itself. The entire body may be affected and oftentimes the face is covered with a complete mask of this disease. With certain subjects the infection is more severe, causing first an inflammation in the gland which acts as a center of explosion and true eczema may follow in any location where the dandriff may have lodged.

Nor is this all. With middle-aged and elderly persons the dandriff is firmly planted in the glands in small patches. These accumulate scales as an irritant, provoking excoriations, warts, and superficial ulcers. When this happens in one predisposed, a true cancer may develop from a single deposit of dandriff. Acting as a foreign body there is first an interference with the function of the skin. The skin cells, or epithelial cells, revert to an embryonic type and under proper stimulus these assume their primitive energy. This is always much in excess of the normal cell. As a result there is a local congestion of active epithelial cells of the original type. Combustion results in the presence of excess of energy and the result is destruction, which may be limited to a small area or which may remove most of the victim's face. And all this may be innocently initiated by a single stroke of a barber's brush.

When we consider that in the several varieties there are something like 1500 skin diseases, it seems a strong statement to say that 20 per cent of the practice of a dermatologist is derived from the barber shop—but this is not an exaggeration. Besides dandriff and its derivatives there are a number of diseases which owe their origin directly and indirectly to the barber shop and to the hairdresser, for he must not be forgotten.

1°. Syphilis. In his book on Syphilis in the Innocent Bulkley gives several instances of syphilis acquired from the barber's razor and shaving brush. Cases have been instanced where the clipper and the alum stick have produced the infection. Nor is it to be wondered at when you consider the usual *modus operandi* of the barber, who shaves a syphilitic, asking no questions as a rule, rubs into the strop whatever of infection the razor may have acquired, collects at the same time more infection in the shaving brush and the next series of victims take chances at infection.

2°. Ringworm. Of the scalp among children; and ringworm of the beard, or barber's itch in the adult. The very frequency of this affection in the beard and its evident source of origin have given it the name of "tinea barbæ" or ringworm of the beard. This is not common among the better classes, but is found among laborers and the artisan class—not uncommonly among barbers themselves, from shops where a single towel serves many offices and where cleanliness looks the shop askance. The infection is rapid enough and when planted the disease stays long. All ringworms are plants of the fungus type and their spores are readily disseminated. In the tinea barbæ form of the disease the mycotic action attacks the tender hair follicle as well as the skin. Feeding as it does on the hairy element of the skin (called the keratin), the parasite grows down into the follicle and gradually destroys the lining of this, often involving the hair shaft in the process. The resultant infection with other organisms causes swelling and a mass of pus inside the gland. The final picture shows a part or all the hairy face, lip, chin and cheeks, either marked or covered with deep seated pustules, crusted or oozing out their putrid contents—bald patches of the beard here and there marking the progress of the disease. And the barber shop is the sole source of origin of this disease!

3°. Ordinary pus infection of the face and of the neck is quite common. The clipper used by the barber leaves a few glands on the neck infected. These either slowly grow inflamed and break down and the process stops with a simple folliculitis (inflammation of the follicle, or gland) or there may continue to develop other infected glands, at times growing into boils or even offering sites for carbuncles.

On the face the same condition may result so far as gland infection is concerned. Either here and there a hair root is affected, a pustule forms and goes its usual way, or in varying attacks a mass of these may form because of their spread in ordinary washing of the face.

4°. "Indian Fire" (Impetigo Contagiosa of the texts) is a common barber shop derivative. The disease is more often one of children—but even the best barber shops may spread this disease through the razor and the shaving brush. It has a rapid course. Beginning with a small blister, or several of them, these rapidly grow into a maximum size of a finger nail and then fill with pus, break and crust with a mass of dirty brown and yellow scabs and pus. Each one of these crusted patches acts as a fresh focus and from these fulminate other spots, developing often in numbers over night or almost as you watch them in the day. The whole body may be covered by the disease, which is really inoculated from point to point on the body. A single spot on a face shaven by the barber and brushed by the shaving brush would be sufficient to spread the disease to every person following such a one in the barber's chair!

5°. Lice. Twice have I seen heads clotted with the eggs, or nits of the head louse, contracted by ladies in two of the best hairdressing establishments in New Orleans—and women are not much more particular than men in their objection to a common comb or common brush—only they frequent the shop much less often than men do.

There are other less common diseases which come from barber shop infection, such as lupus, herpes, molluscum, blastomycosis, etc., but these are enough to point the moral that the barber shop in modern society is a menace so long as the conditions which govern its management are allowed to exist. Many shops strive towards cleanliness because their customers have demanded it—but all shops are dirty, some worse than others.

A crusade has started against the evils of the barber shop and in some countries legislative action has followed. In a recent paper in the *British Medical Journal,* Collingridge reviews the status of the question at the time of his writing. There are no regulations in the British Colonies. In Germany four cities, Hamburg, Anhalt, Waldeck and Danzic have restrictions. Lausanne, Vevey and Rolle in Switzerland have laws; Sweden, Turkey, Japan, Bolivia, Salvador and Uruguay, also. These are named by Dr. Collingridge, who also mentions New York as the only State where the licensed barber must conform to regulations. While Vienna began to legislate rules for barber shops some years back, her action has been followed rather generally in other European countries. In most places regulations are directed at cleanliness, antisepsis and prevention, and infringement is punishable by fine—sometimes heavy. In Switzerland barbers with hair or skin diseases are not allowed to carry on their calling.

In 1899, Sweden legislated regarding the prevention of skin diseases transmitted by shaving.

In 1901, in Constantinople, regulations were promulgated regarding cleanliness in the barber shops. Even Guatemala has taken some action aimed at regulating the barber shop evils.

Collingridge considers the present state of things in London discreditable to a civilized nation—and yet the London barber shops of the better class are far cleaner than those of the same class in the United States.

Several of the Canadian provinces have taken action in the matter of protecting the public in the barber shops; Montreal has, notably, in careful detail, issued rules which carry directions as to the minutest detail of care of the razor and utensils. Towels are to be sterilized, puffs and miscellaneous mops and face brushes dispensed with, etc.

The dangers of the barber shop have been recognized sufficiently to almost demand some regulation of the methods in vogue. The Ontario Legislature passed laws fully five years ago and in Montreal the law is particularly enforced. New Jersey has decided through the Supreme Court that the Board of Health has the power to make provision for regulating the hygiene of the barber shop.

Missouri has a State Board of Examiners for barbers with authority to make rules.

The law at present in Missouri is along the lines of the original Vienna law. Indiana, Michigan, New York, Vermont, Ohio, Connecticut have each laws like this. The Missouri law is as follows: (*St. Louis Courier of Medicine,* Vol. 29, 1903, p. 381.)

After providing for proper inspection of shops, the following rules have been promulgated for the guidance of barbers:

1°. "No razor, pair of shears or clippers used upon any person shall be used upon any other person until such razor, pair of shears or clippers shall be sterilized by immersion, for not less than five minutes, in a 1% solution of trikresol.

(Trikresol is a powerful disinfectant, is cheap and can readily be obtained at drug stores. It does not injure the instrument.)

2°. "No towel, whether a dry or a hot towel, shall be used upon any customer, unless such towel shall be clean and such towel must be boiled before being again used.

3°. "No cup or lather brush shall be used upon any customer until such cup and brush shall be thoroughly washed in boiling water.

4°. "The floor, walls, furniture and fixtures of every barber shop shall be kept clean. Every cuspidor and waste paper bowl shall be cleansed with boiling water at least once every 24 hours. No loose hair shall be allowed to accumulate on the floor of any barber shop.

5°. "Every barber while on duty in his shop, shall be neat and clean in his personal appearance. Every barber shall wash his hands thoroughly before serving a customer, and on serving another customer shall again wash his hands.

6°. "No barber who has any venereal or other contagious disease shall practice his trade. No proprietor of any barber shop shall retain in his employ any barber known to have any venereal or any other contagious disease.

7°. "The use in barber shops of finger bowls, powder puffs and sponges, is prohibited and no barber shall keep either of them on his working stand.

8°. "All combs, hair brushes, hair dusters and other articles used upon the persons of customers, shall be at all times kept thoroughly clean and washed at frequent intervals with water of ammonia or solution of borax. All soap, perfume, bay rum, witchhazel and other toilet articles and all antiseptic solutions, shall be of good quality.

9°. "No barber shop shall be considered to be in a sanitary condition if any part of said shop is used as a living, cooking or sleeping apartment."

An analysis of these rules shows them to be thoroughly practical but not far-reaching enough.

The barber shop is a necessary evil of civilization—largely because men wear short hair and are either too lazy to shave or find the barber less severe than themselves. The barber shop is a commodity and as such should be regulated. Whatever law applies should be directed at making cleanliness and the prevention of disease the elemental objects. The Missouri law is effective so far as rules of cleanliness are concerned, but not in preventing disease. I have long taught that the hair brush and the shaving brush were the two prime factors in provoking disease in barber shops. Eliminate these two and require sterilization of instruments and the conditions are improved at once. A sterile bath with soap sud boiling water followed by a formalin solution applied and wiped off with a clean cloth will keep scissors, clippers, razors, combs clean.

The first-class French barber does not employ cake soap in shaving a patron—he uses liquid which is deftly applied with the fingers. Some shops use lint or cotton mops, and the cosmetic of the shop may be employed by such media, to be thrown away once used.

The barber shop is an evil and a remediable one—and the method is much simpler in fact than in practice. A barber shop fulfilling the highest ideal of hygienic principle should need no law for its proper regulation—for the rules could be made so simple:

"This barber shop uses no brushes!

"All instruments are sterilized before being used on each customer.

"Persons with diseases of the skin on face or scalp are not served here.

"Barbers with a skin or venereal disease are not employed here."

Associate these with general cleanliness and such a shop will reap a harvest.

But on the other hand—the patron himself is often careless. My own barber secretly confides to me that Mr. B., whom I am treating, insists on having his hair brushed; he, the barber, knows that I must have forbidden a brush. How many men hesitate to use a hair brush at the hotel, or even at the club? At every private or public entertainment the dressing room invites the mixed use of brushes and combs—and yet every guest would be shocked at the invitation to use a common toothbrush if it were suggested as baldly! Nevertheless the toothbrush would be far the cleaner of the lot!

The public has so long deserved some protection against itself that any plea to that end must be taken as public spirit. The City, State and Nation have begun crusades against evils in food products, drugs, domestic supplies, and where flagrant offense has been committed, the violators are punished. If it were realized that every day thousands of persons were being exposed to contagious disease by the practice of the barber, is it at all likely that any protection would be afforded?

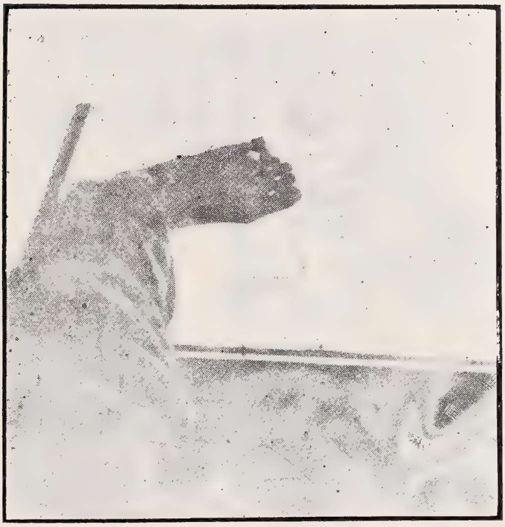
Clinical Report.

Cases of Raynaud's Disease and Ainhum.

By B. A. COLOMB, M. D., Union, La.

"RAYNAUD'S DISEASE": L. J., female mulattress, age 44 years, neurotic temperament and always sickly. No hereditary tendencies. In the month of November, 1904, was taken rather suddenly with pain and swelling of the right middle finger at the second joint. Referred the trouble to the use of scissors. The entire hand and digits soon swelled, and became intensely painful, the pain extending over the whole arm. The finger was lanced on three separate occasions for a felon, with much relief, but with only temporary benefit. About January, 1905, the diseased digit became dark and anesthetic in spots near the tip, and the other digits commenced to waste and slowly contract. About March 1, 1905, the gangrenous spots had extended to the second joint, with very little sensation in

New Orleans Medical and Surgical Journal,
August, 1905.



Dr. Colomb's Case of Ainhum.

the diseased part, but great pain in the arm and finger. All the other digits were flexed, rigid and wasted. The finger was removed just above the diseased part, under cocain anesthesia. The vascularity was normal, and healing was by first interior throughout. Pain has gradually subsided, and on April 15, is relieved entirely, but the contraction and rigidity are still present. The only medical treatment was iron, quinin, arsenic and strychnin, with a full diet.

"AINHUM": G. M., negro man, age 44 years, always healthy, no hereditary history. About 10 years since noticed what he thought was a corn, between the small and second toes of his left foot. This he removed from time to time, as a hard, painless substance. There was a continual reproduction of this cartilaginous material in increasing extent, until it gradually extended around the entire base of the toe. During this time, the patient removed many rings of horny substance, each leaving the furrow deeper, and pain developed at the site of the constriction, which is now the seat of an intense boring pain. April 10, 1905, the toe presented a bulbous appearance, was almost anesthetic in the distal portion, highly sensitive at and above the sulcus, and nearly separated from the foot. On the inner side, the bone was exposed and eroded, and this part was exceedingly sensitive. The amputation was completed under cocain anesthesia, as the patient would not consent to division higher up.

Louisiana State Medical Society Proceedings.

[Edited by Publication Committee.]
In charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

Dr. L. G. LeBeuf read a paper entitled

"Acute Pneumonia and Its Modern Treatment."

In selecting this subject for discussion this year, before the Section of General Medicine, I do not intend to attempt a thesis or an elaborate article on this most comprehensive of subjects, as that belongs more to your Text-Books or to your college Professors; I merely want to attempt from the clinician's standpoint to discuss our present mode of procedure in the management of our cases, and to place before you some few conclusions secured by the analysis of statistics taken from amongst the membership of this Society. The great desideratum primarily with all of us is to find or adopt some plan of treatment which will diminish the appalling mortality of this disease. Apparently very little has been accomplished in this way, and pneumonia is still the most fatal of all acute diseases, even outranking consumption and diphtheria. For while we may succeed in diminishing the mortality of diphtheria with antitoxin, or greatly reduce that of consumption, by a better understanding of the hygiene of its treatment, with the outdoor rest cure, forced nutrition and serums, it is a most sad thing to confess that in pneumonia, even with our immense armamentarium of new drugs and modern technic, we have not lowered the mortality rate at all in the last decade.

At the 1902 meeting of the American Medical Association, at Saratoga, Prof. Osler, discussing a paper on pneumonia, said: "When we think that other infectious diseases we treat have their mortality reduced some 10 or 15 per cent, it is terrible to realize that we, as physicians, must listen with mute, impassioned faces to the announcement of a *36 per cent mortality* in pneumonia. What I deeply feel is that something should be done in a systematic and energetic way to study this problem of pneumonia and see if one cannot reduce this mortality of 36 per cent."

It should be as much a victory to save a case of pneumonia as to save one from appendicitis.

In hospital practice the mortality varies from 20 to 40 per cent. In private practice from 12 to 20 per cent. At the Montreal General Hospital the mortality on 1,012 cases was 20.4 per cent. That is in the extreme North; in the extreme South it seems to be even more fatal than this. Here in New Orleans, where the negro wards often contain 10 pneumonia cases to each ward, at a given time, a tabulation of 3,969 cases treated at the Charity Hospital shows a mortality of 38.01 per cent. At the Johns Hopkins Hos-

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ACUTE PNEUMONIA.

Case 1—Age, 30; colored; max. temp., 104; pulse, 112; resp., 42; termination, crisis or lysis, crisis 6th day; location, Rt. lower L.; result, recovy.; complications, none; bacteriological ex., pneumococci; treatment, strych. and diet.

Case 2—Age, 24; white; max. temp., 105; pulse, 130; resp., 48; termination, lysis on 11th day; location, middle lobe; result, recovy.; complications, malaria; bacteriological Ex., malaria plas. and pneumococci; treatment, strych. and quinine.

Case 3—Age 48; white; max. temp., 96; pulse, 126; resp., 48; location, Rt. base apx.; result, death; complications, none; bacteriological Ex., none; treatment, strych., flaxseed poultice.

Case 4—Age, 11; white; max. temp., 103; termination, lysis 12th day; location, Rt. base; result, recovy.; complications, none; bacteriological Ex., none; treatment, Am. chlor., Brown's Rx., poultices.

Case 5—White; max. temp., 99; resp., 36; termination, lysis 19th day; location, Rt. base; result, recovy.; complications, none; bacteriological Ex. none; treatment, Am. carb., iodide, poultices.

Case 6—Age, 86; white; max. temp., 102; location, both bases; result, died; complications, endocard.; bacteriological Ex., none; treatment, strych., Am. chlor.

Case 7—Age, 20; colored; max. temp., 102; pulse, 120; resp., 32; location, both bases; result, died; complications, none; bacteriological Ex., none; treatment, strych., Am. chlor.

Case 8—Age, 32; colored; max. temp., 103; pulse, 120; resp., 32; termination, crisis, 5th day; location, Rt. base; result, recovy.; bacteriological Ex., pneumococci; treatment, strych. 1–30.

Case 9—Age, 21; colored; max. temp., 105; pulse, 110; resp., 35; termination, lysis, 26th day; location, Rt. apex; result, recovy.; complications, jaundice; bacteriological Ex., none; treatment, sodium phos.

Case 10.—Age, 27; white; termination, lysis, 15th day; location, both bases upper lobe; result, recovy.; complications, none; bacteriological Ex., none; treatment, camphor gr. 1., strych. gr. 1/30.

Case 11 —Age, 25; white; max. temp., 104; resp., 40; termination, crisis 7th day; location, Rt. base; result, recovy.; complications, interstitial nephritis; bacteriological Ex., pneumonococci; treatment, strych., poultices, Besham's Rx.

Case 12—Age, 38; white; max. temp., 101; pulse, 135; resp., 50; location, L. and B. bases; result, died; complications, interstitial nephritis; bacteriological Ex., none; treatment, strych.

Case 13—Age, 13; white; max. temp., 96; pulse, 145; resp., 50; location, Rt. base; result, died; complications, endocard.; bacteriological Ex., pneumococci; treatment, Am. chlor., Ac. Spts. Ammonia, strych., iodide.

Case 14—Age, 55; white; max. temp., 103; pulse, 125; resp., 40; termination, crisis, 6th day; location, L. base; result, recovy.; complications, none; bacteriological ex., pneumococci; treatment, strych., Ammon., carb., spts., ipecac.

pital the death rate is 25 per cent for the white and 30 per cent for the black. In the Pennsylvania Hospital it is 29 per cent, at the Boston City Hospital it is 29.1 per cent. What an immense army of useful lives are taken away every year from their active field of work, and were we to attempt to compute this loss in dollars and cents, think of the tremendous sums this would reach. This disease seems to be more fatal in the extreme ages. Under one year and above sixty the mortality is very high. It was the importance of this subject and the number of articles appearing lately in the medical press that caused me to make this compilation of experiences taken from the members broadcast throughout the state, in the city as well as in the country and to

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Case 15—Age, 19; white; max. temp., 104; pulse, 120; resp., 35; termination, crisis 4th day; location, R. base; result, recovy.; complications, malaria; bacteriological Ex., pneumococci, tertian-plasmodia; treatment, quinine, S. sulph.

Case 16—Age, 30; white; max. temp., 103; pulse, 120; resp., 40; location, L. base; result, died; complications, malaria; bacteriological Ex., pneumococci; treatment, quinine, S. camphor, blisters.

Case 17—Age, 24; colored; max. temp., 105; termination, crisis, 8th day; location, R. base; result, recovy.; complications, none; bacteriological Ex., none; treatment, Tr. Strophanth, strych.

Case 18—Age, 19; colored; max. temp., 103; resp., 30; termination, lysis, 20th day; location, R. apex; result, recovy.; complications, acute neph.; bacteriological Ex., none; treatment, strych., digitalis, Am. chloride.

Case 19—Age, 84; white; max. temp., 107; resp., 40; location, R. base; result, died; treatment, strych., digitalis, amon., chlor., poultice.

Case 20—Age, 43; white; max. temp., 101; termination. crisis, 8th day; location, R. base; result, recvy.; bacteriological Ex., pneumococci; treatment, strych., ammonia, iodide.

Case 21—Age, 29; white; max. temp., 101; pulse, 118; resp., 40; termination, crisis, 5th day; location, both bases; result, recovy.; bacteriological Ex., staphylococci; treatment, strych., am., iodide, chlor.

Case 22—Age, 33; colored; max. temp., 104; pulse, 120; resp., 35; termination, crisis 7th day; location, R. base; result, recovy.; treatment, strych., poultices.

Case 23—Age, 3; white; max. temp., 104; termination, crisis, 7th day; location, R. base; result, recovy.; treatment, creosote, strych.

Case 24—Age, 27; white; max. temp., 103; pulse, 124; resp., 40; termination, lysis 15th day; location, R. base; result, recovy.; treatment, strych., am., iodide.

Case 25—Age, 33; colored; termination, crisis, 25th day; location, R. base; result, recovy.; treatment, strych., am., chlor.

Case 26—Age, 36; white; max. temp., —; pulse, —; resp., —; termination, lysis, 17th day; location, R. base; result, recovy.; complications, —; bacteriological ex., —; treatment, am., carb., strych.

Case 27—Age, 38; white; max. temp., 103; pulse, —; resp., —; termination, lysis 19th day; location, —; result, recovy.; complications, —; bacteriological ex., pneumococci; treatment, poultices am., iodide.

Case 28—Age, 63, white; max. temp., 103; pulse., —; resp., —; termination, died 7th day; location, R. base; result, died; complications, endocard.; bacteriological ex., —; treatment, strych., digitalis, am., iodide.

Case 29—Age, 26; colored; max. temp., 105; pulse, 160; resp., 80; termination, died 6th day; location, both bases; result, died; complications, —; bacteriological ex., pneumococci; treatment, strych., digitalis, camphor.

Case 30—Age, 60; white; max. temp., 99; pulse, —; resp., 32; termination, died 4th day; location, L. base; result, died; complications, interstitial nephritis; bacteriological ex,, —; treatment, —.

attempt, if possible, to draw some valuable conclusions from our joint experiences. If we have learned so much from bacteriology of this disease, from the micrococcus lanceolatus and of the diplococcus pneumoniæ of Fraenkel and Weichselbaum, or of its pathology, of its morbid anatomy and symptomatology, should we not also have learned something of a more successful treatment. Prophylaxis and hygiene will help to this end undoubtedly.

During a recent visit made to the Hospital General in Mexico City, I was much pleased to see that pneumonia is treated there in a separate *Pavilion de Infectiosas,* just as if it were smallpox or consumption.

Some years ago I was ordered to make an investigation, together with several physicians, regarding the cause of the high death rate of a state convict camp—eighteen convicts had died within a few weeks. We found, as we had been told by the attending physicians, an epidemic of measles, but after holding three postmortems we also called the condition ac. lobar-pneumonia of an infectious type, and after some corrections about the drinking

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Case 31—Age, 55; white; max. temp., 101; pulse, 120; resp., 60; termination, died 11th day; location, L. base; result, died; complications, def. nephritis; bacteriological ex., —; treatment, am., iodide, poultice.

Case 32—Age, —; colored; max. temp., 102; pulse, —; resp., —; termination, died 6th day; location, L. apex; result, died; complications, pul. abscess, tuberculosis; bacteriological ex., —; treatment, —.

Case 33—Age, 53; colored; max. temp., 103; pulse, 130; resp., 44; termination, crisis 5th day; location, R. base; result, recovy.; complications, —; bacteriological ex, —; treatment, strych., tr. strophanthus, poultice.

Case 34—Age, 24; white; max. temp., 104; pulse, 110; resp., 45; termination, death 13th day; location, R. M. lobe; result, died; complications, dysentery; bacteriological ex., pneumococci; treatment, strych., am., carb., poultices.

Case 35—Age, 39; colored; max. temp., 103; pulse, 110; resp., 36; termination, crisis 12th day; location, R. base; result, recovy.; complications, —; bacteriological ex., pneumococci; treatment, strych., camphor, am., carb.

Case 36—Age, 9; colored; max. temp., 95; pulse, 160; resp., 62; termination, death 24th day; location, whole left lung; result, died; complications, —; bacteriological ex., —; treatment, —.

Case 37—Age, 24; colored; max. temp., 103; pulse, 100; resp., 53; termination, crisis 10th day; location, R. base; result, recovy.; complications, —; bacteriological ex., —; treatment, am. chlor., strych.

Case 38—Age, 32; colored; max. temp., 104; pulse, 130; resp., 55; termination, crisis 12th day; location, R. base; result, death; complications, empyema; bacteriological ex., —; treatment, strych., creosote.

Case 39—Age, 22; white; max. temp., 102; pulse, 120; resp., 34; termination, died 5th day; location, both bases; result, died; complications, —; bacteriological ex., —; treatment, am. carb., strych.

Case 40—Age, 22; white; max. temp., 105; pulse, 120; resp., 30; termination, died 5th day; location, R. base and middle lobe; result, died; complications, tuberculosis; bacteriological ex., —; treatment, —.

Case 41—Age, 14; white; max. temp., 104; pulse, 135; resp., 68; termination, crisis 10th day; location, —; result, recovy.; complications, —; bacteriological ex., —; treatment, am. carb., strych., digitalis, hyoscin.

water, with complete separation, and a general improvement in the food and body hygiene the evil was quickly stopped.

In practice we all have our special pet treatment for pneumonia, and we all have some personal pride regarding the percentage of our recoveries; few of us are perfectly honest regarding that mortality. The only absolute proof of those results are statistics. It is not very difficult for any of us to look back over our past records —we nearly always keep a ledger of the accounts due us or already paid to us, and all we have to do is to read over some of the names that appeared there some years ago and which do not appear any more. That is the crucial test. I trust that my confréres can look back with more comfort on their past management of pneumonia than I can. My entire *modus operandi* has been changed within these last few years. My treatment now is expectant, supportive, as the heart calls for such, and absolutely non-interference with drugs. This method is built upon, first, an edifice of theory, and again on one of experience, supported by the results of many post-mortems.

In answer to my two circular letters, one in November, and

Case 42—Age, 33; colored; max. temp., 103; pulse, —; resp., —; termination, lysis 13th day; location, both bases; result, recovy.; complications, deffust, neph.; bacteriological ex., pneumococci; treatment, strych., digitalis, poultices.

Case 43—Age, 41; white; max. temp., —; pulse, —; resp., —; termination, crisis 9th day; location, R. base; result, recovy.; complications, —; bacteriological ex., —; treatment, strych., digitalis, Basham's Rx.

Case 44—Age, 25; colored; max. temp., 105; pulse, —; resp., —; termination, lysis 10th day; location, L. base; result, recov.; complications, —; bacteriological ex., treatment, strych., digitalis, syr. codein.

Case 45—Age, 10; white; max. temp., 102; pulse, 120; resp., 48; termination, lysis 20th day; location, L. base; result, recovy.; complications, —; bacteriological ex., —; treatment, strych., digitalis, poultices.

Case 46—Age, 6; colored; max. temp., 103; pulse, 140; resp., 88; termination, lysis 15th day; location, L. base; result, recovy.; complications, —; bacteriological ex., pneumonococci; treatment, strych., am., cloride.

Case 47—Age, 21; white; max. temp., 105; pulse, 120; resp., 32; termination, crisis 9th day; location, whole R. lung; result, recovy.; complications, —; bacteriological ex., —; treatment, strych., creosote.

Case 48—Age, 50; white; max. temp., 103; pulse, 120; resp., 36; termination, crisis 7th day; location, L. base; result, died; complications, —; bacteriological ex., —; treatment, strych., am. chloride.

Case 49—Age, 28; white; max. temp., 103; pulse, 135; resp., 55; termination, death 19th day; location, L. base; result, death; complications, —; bacteriological ex., —; treatment, strych., am., chloride.

Case 50—Age, 22; white; max. temp., —; pulse, —; resp., —; termination, crisis 7th day; location, R. base; result, died; complications, intesti. nephr.; bacteriological ex.; —; treatment, strych., am., chloride.

Case 51—Age, 24; colored; max. temp., 102; pulse, 100; resp., 32; termination, crisis 3d day; location, —; result, —; complications, —; bacteriological ex., —; treatment, strych., digitalis, poultices.

Case 52—Age, 3; white; max. temp., 104; pulse, —; resp., —; termination, crisis 7th day; location, —; result, died: complications, —; bacteriological ex., —; treatment, brandy, poultices.

again one in April asking the members to keep a record of their cases of pneumonia with maximums of temperature, location of disease, whether termination was by crisis, and on what day, and, if by lysis, what intercurrent condition causing it. If any bacteriological examination had been made, the result of this, and finally a brief synopsis of their treatment—then the results. This was answered by forty members and twenty-seven sent their cases with reports. Many discussed the treatment quite freely, and most ably; a large majority showing a marked tendency to conservatism, by a very much curtailed list of medicinal agents used. Various letters received deserve to be published in full on account of their ability and their broad-mindedness. I cannot thank my confréres too much for their assistance. For after all it is only facts which count for anything, and they are the only arguments which should be used. Referring to the tabulation of the 170 cases which I have endeavored to place together in a very crude manner, I hope you will agree with me that the conclusions justify the method of treatment adopted. If we follow Flint, Tyson, Osler and others, we believe that pneumonia is an infectious disease, or an essential fever caused by a specific organism or infection, always characterized by inflammation of the cells, the alveolar epithelium and the capillaries of the lung. It is a fever which terminates abruptly by

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Case 53—Age, 20; colored; max. temp., 102; pulse, —; resp., 28; termination, crisis 7th day; location, L. lung; result, died; complications, —; bacteriological ex., pneumococci; treatment, strych., am. chloride.

Case 54—Age, 47; white; max. temp., 103; pulse, —; resp., —; termination, crisis 7th day; location, L. apex; result, died; complications, —; bacteriological ex., —; treatment, strych., am., carb., and potass citrate.

Case 55—Age, 35; white; max. temp., 102; pulse, —; resp., —; termination, crisis 4th day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., am. carb. and potass citrate.

Case 56—Age, 7; white; max. temp., —; pulse, —; resp.. —; termination, crisis —; location, —; result, died; complications, —; bacteriological ex., —; treatment, strych, am., chlor.

Case 57—Age, 42; white; max. temp., 104; pulse, —; resp., —; termination, died 3d day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., am., chlor.

Case 58—Age, 33; colored; max. temp., 104; pulse, 120; resp., 40; termination, crisis 4th day; location, R. base; result, recvy.; complications. —; bacteriological ex., —; treatment, am. chlor., poult.

Case 59—Age, 35; white; max. temp., 103; pulse, 110; resp., 32; termination, lysis 21st day; location, L. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. carb., spts. chloroform.

Case 60—Age, 75; colored; max. temp., 102; pulse, 120; resp., 35; termination, lysis 13th day; location, both bases; result, died; complications, chr. endocard. and nephritis; bacteriological ex., pneumococci; treatment, strych., digitalis, am. muriat.

Case 61—Age, 32; white; max. temp., 105; pulse, 180; resp., 48; termination, died 4th day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., digitalis, am. muriat.

crisis between the 5th or 9th day. The micrococcus lanceolatus of Fraenkel is present in a large proportion of cases—some authors say that it is present always when a large amount of blood is examined. If it is true then that pneumonia is a general disease with a local lung lesion as a constant phenomenon, why should we give the assiduous care to the treatment of the pathology of the lung proper. For if we watch the clinical course carefully, we find, that on the 5th, 6th or 7th day a defervescence or crisis has taken place, the fever has gone down, the pain stopped, dyspnœa, if any, is relieved, and the patient is in a pleasant sweat; *but still,* the physical signs are about the same, the lung is just as much consolidated, the alvoeli are still enlarged, still containing as much fibrin, cellular detritus, and diplococci as before. This favorable change of the condition of the patient has taken place apparently without the influence of any drug. It has come on by itself, when you should have thought that the other physical signs or lesions should have disappeared or have been affected by this happy termination. It is only a day or two later that the *râle redux* is heard and resolution takes place. Certainly if drugs had caused this change we would see this effect also on those organisms sooner, but on the contrary they remain just as active as before. This little clinical observation has helped to convince me more than

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Case 62—Age, 54; white; max. temp., 104; pulse, 160; resp., 40; termination, crisis 7th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, strych., digitalis.

Case 63—Age, 16; white; max. temp., 104; pulse, 110; resp., 40; termination, crisis 9th day; location R. base; result, recvy; complications, —; bacteriological ex., —; treatment, strych., creosote-carb.

Case 64—Age, 42; colored; max. temp., 103; pulse, 130; resp., 45; termination, died 6th day; location, —; result, died; complications, —; bacteriological ex., pneumococci; treatment, strych., digitalis, iodide.

Case 65—Age, 56; white; max. temp., 101; pulse, —; resp., —; termination, lysis 26th day; location, base; result, recvy; complications, —; bacteriological ex., —; treatment, —.

Case 66—Age, 24; colored; max. temp., 105; pulse, 122; resp., 42; termination, died 24th day; location, whole right lung; result, died; complications, —; bacteriological ex., —; treatment, —.

Case 67—Age, 25; white; max. temp., 104; pulse, —; resp., 60; termination, died 6th day; location, L. base; result, died; complications, —; bacteriological ex., —; treatment, strych., poultices.

Case 68—Age, 38; colored; max. temp., 106; pulse, 106; resp., 50; termination, died 3rd day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., digitalis, am. chlor.

Case 69—Age, 35; colored; max. temp., 104; pulse, 102; resp., —; termination, crisis, 9th day; location, R. base; result, recvy; complications, —; bacteriological ex., pneumococci; treatment, am. iodide, poultices.

Case 70—Age, 29; colored; max. temp., 102; pulse, 115; resp., 32; termination, crisis 4th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, strych., digitalis, am. chlor., poultices.

anything else that pneumonia was a general disease, whose tendency was self limited always, eager to get well by itself without influence of drugs.

La pneumonie franche, as Dujardin-Beaumetz calls it, can never be aborted—if some of us believe we have accomplished such a feat I suppose we have only relieved a case of pleurodynia, of acute pleurisy or of plain bronchitis.

In the discussion of the action of drugs and their effects I will merely try to give in a very simple way of reasoning, their effects and the condition of the symptomatology calling for them. I am not in a position to explain the exact body metabolism which takes place nor the morphological effects thoroughly, but probably the deductions in treatment will be as useful.

Let us quickly see what happens in the lung, and what we are called to relieve. Our patients are rarely seen in the earliest stage or the first few hours of the onset or stage of congestion, which is generally characterized by a chill. The physical signs are: (a) Circumscribed area of feeble and indistinct breathing, in com-

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Case 71—Age, 43; white; max. temp., 104; pulse, 120; resp. 60; termination, died 1st day; location, whole R. lung; result, death; complications, —; bacteriological ex., —; treatment, strych., digitalis, camphor poultices.

Case 72—Age, 26; colored; max. temp., 104; pulse, 120; resp., 44; termination, lysis 30th day; location, R. base; result, recvy; complications, —; bacteriological ex., pneumococci; treatment, am. iodide, strych.

Case 73—Age, 70; white; max. temp., 106; pulse, —; resp., —; termination, died 9th day; location, R. apex; result, died; complications, endocard. and nephritis; bacteriological ex., —; treatment, am. chlor., strych., camphor.

Case 74—Age, 21; white; max. temp., 103; pulse, 115; resp., 43; termination, crisis; location, L. base; result, recvy.; complications, influenza; bacteriological ex., pneumococci; treatment, strych., am. chlor.

Case 75—Age, 55; colored; max. temp., 102; pulse, 120; resp., 40; termination, died 1st day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., am. iodide.

Case 76—Age, 28; colored; max. temp., 102; pulse, 138; resp., 90; termination, died 4th day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, strych., digitalis, am. carb.

Case 77—Age, 29; colored; max. temp., 103; pulse, —; resp., —; termination, died 4th day; location, L. base; result, died; complications, syphil.; bacteriological ex., —; treatment, strych., am. chlor.

Case 78—Age, 35; white; max. temp., 104; pulse, 128; resp., 40; termination, crisis 9th day; location, L. base; result, recvy; complications, —; treatment, strych., digitalis, am. carb.

Case 79—Age, 19; colored; max. temp., 103; pulse, 115; resp., 35; termination, crisis 4th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment. strych., am. carb.

Case 80—Age, 43; max. temp., 105; pulse, —; resp., —; termination, died 3d day; location, L. base; result, died; complications, —; bacteriological ex., —; treatment, am. carb. and creso., digitalis.

Case 81—Age, 25; white; max. temp., 104; pulse, 128; resp., 40; termination, lysis 15th day; location, R. base; result, recvy; complications, —; bacteriological ex., pneumococci; treatment, am. iodide.

Case 82—Age, 42; white; max. temp., 102; pulse, 98; resp., 32; termination, lysis 14th day; location, L. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. carb., ice bag.

parison with the normal state; (b) a localized difference or diminution of resonance on percussion; (c) crepitant râles (or fine râles heard at the end of inspiration only), and (d) slight increase in intensity and clearness of vocal resonance; (e) also some slight exaggeration of bronchial breathing. This stage or the *first stage,* has also a high fever, a rapid hard tense pulse with fast respiration—generally a severe pain in the side and a short, dry and painful cough. This stage lasts one or two days; then we have the *second stage,* or the stage of red-hepatization when the symptoms and the signs are absolutely pathognomonic. The blood and serum with other detritus, micrococci, staphylococci and streptococci which had begun filling the air cells and smaller bronchia are now solid fibrous plugs of coagulated matter. The alveolar walls are infiltrated, and leucocytes are seen in the interlobular tissues. The signs during this stage are very typical and can hardly be mistaken—a patient lying down perfectly flat, usually on the side affected, with a flushed face, rapid breathing, with a peculiar, jerky, expiratory groan, anxious expression of the face, fever blisters or herpes around the mouth, painful cough with tendency to shorten the effort of coughing and holding the side affected during the cough. The rusty colored expectoration, blood tinged

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Case 83—Age, 29; white; max. temp., 104; pulse, —; resp., 28; termination, crisis 8th day; location, R. base; result, recvy; complications, —; bacteriological ex., pneumococci; treatment, am. carb., strych.

Case 84—Age, 59; white; max. temp., —; pulse, —; resp., —; termination, lysis; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. carb., strych.

Case 85—Age, 34; colored; max. temp., 103; pulse, 110; resp., 40; termination, died 2nd day; location, R. base; result, died; complications, —; bacteriological ex., pneumococci; treatment, strych., digitalis, am. chlor.

Case 86—Age, 19; colored; max. temp., 104; pulse, 128; resp., 48; termination, crisis 10th day; location, R. base; complications, —; bacteriological ex., —; treatment, strych., ice bag.

Case 87—Age, 22; colored; max. temp., 103; pulse, 120; resp., 40; termination, crisis 9th day; location, R. base; result recvy; complications, —; bacteriological ex., —; treatment, am. iodide, poultice.

Case 88—Age, 40; white; max. temp., 105; pulse, —; resp., — termination, lysis 43rd day; location, R. base; result, recvy; complications, —; pneumococci; treatment, strych., C. L. oil.

Case 89—Age, 5; white; max. temp., 103; pulse, 125; resp., 40; termination, crisis 9th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. chlor., potass., syrup ipecac.

Case 90—Age, 35; colored; max. temp., —; pulse, —; resp., —; termination, lysis 13th day; location, L. apex; result, recvy; complications, —; bacteriological ex., —; treatment, am. iodide, strych.

Case 91—Age, 22; colored; max. temp., —; pulse, —; resp., —; termination, crisis 4th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. iodide, poultice.

Case 92—Age, 20; colored; max. temp., 104; pulse, 108; resp., 88; termination, lysis 27th day; result, —; complications, —; bacteriological ex., —; treatment, am. iodide, poultice.

and sticky; high temperature, full, bounding pulse, respiration very fast and short. The *physical signs,* dullness on percussion, even flatness, blowing breathing, tubular in character and fine râles. Then this stage ends abruptly by a well marked crisis on the 5th, 6th or 7th day—the *physical signs* still keep up for a day or two more, and then we have gray hepatization with the same physical signs, but a different picture histologically, for the air cells have lost their fibrin and red blood cells and are now leucocytes. Then either this is the first stage of resolution with *râles redux* and returning air in the consolidated cells, or on the other hand in the fatal cases many small abcesses take place with great spread of septic purulent material and general septicemia or toxæmia and then death. This rapid sketch of the morbid anatomy is given merely to better understand the medicinal agents suggested and the time for their appropriate application.

First—The first thing, and that to me is primary and to take precedence over all things, is the *diet* or the proper feeding, or support of the patient's strength by a liquid, but a free and ample amount of nourishment. The better nutrition of our patients the better a fight will be made by the vital powers of that patient—so

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Case 93—Age, 64; white; max. temp., 103; pulse, —; resp., —; termination, lysis 16th day; location, R. middle lobe; result, recvy.; complications, nephritis; bacteriological ex., —; treatment, strych., digitalis, diuretics.

Case 94—Age, 59; white; max. temp., 104; pulse, 128; resp., 55; termination, lysis 13th day; location, L. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. carb., potass-acetate.

Case 95—Age, 19; colored; max. temp., 104; pulse, 120; resp., 42; termination, lysis 16th day; location, R. base; result, recvy; complications, —; bacteriological ex., —; treatment, am. iodide, poultice.

Case 96—Age, 19; colored; max. temp., 105; pulse, 115; resp., 35; termination, lysis 15th day; location, R. base; result, recovery; complications, —; bacteriological ex., —; treatment, am. chlor., strych., creosote carb.

Case 97—Age, 53; white; max. temp., 104; pulse, 130; resp., 38; termination, died 2d day; location, whole R. lung; result, recovery; complications, —; bacteriological ex., —; treatment, strych., digitalis, ammon. chlor., spts. camphor.

Case 98—Age, 25; colored; max. temp., 103; pulse, —; resp., —; termination, died 6th day; location, both bases lobe; result, died; complications, nephritis; bacteriological ex., —; treatment, strych., digitalis, diuretics.

Case 99—Age, 23; colored; max. temp., —; pulse, —; resp., —; termination, lysis 11th day; location, R. base; result, died; complications, —; bacteriological ex., —; treatment, am. carb. and poultices.

Case 100—Age, 19; colored; max. temp., 104; pulse, 116; resp., 60; termination, died 3d day; location, R. apex; result, died; complications, —; bacteriological ex., —; treatment, am. carb., creosote.

Case 101—Age, 50; white; max. temp., 103; pulse, 132; resp., 40; termination, died 3d day; location, R. base; result, died; complications, —; bacteriological ex., —; strych., digitalis, camphor.

Case 102—Age, 22; white; max. temp., 105; pulse, 120; resp., 35; termination, lysis 16th day; location, R. base; result, recovery; complications, —; bacteriological ex., —; am., iodide, poultices.

many cases of pneumonia die practically from inanition, *mort guèri,* as the French call it,—after the disease has had its course, and the blood and brain have become carbonated by a lack of oxygen or after the right heart has been exhausted by the terrific battle it has just fought. If you do not sustain your patient with a good, wholesome rich diet, easily assimilable, you will lose him *mort guéri,* indeed. I use all through pneumonia milk, and if there is too much flatulence, or the milk disagrees with patient, I peptonize it or mix it with vichy or lime water to help alkalinize it. Barley-water, chicken-tea, liquid peptonide, panopepton or Ducro's elixir, then later, when the condition of the patient allows, soft boiled eggs or raw eggs beaten with milk or sherry or beef bouillon, junket to remove caseation of milk, whey or strained oat-meal or thin hominy gruel. By all means feed your patients, even if it is only with water—at least use some food every hour. You will find their cases will run a shorter course, and a milder one—the convalescence is certain to be shorter. Remember that it is fuel that

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Case 103—Age, 27; colored; max. temp., 103; pulse, 120; resp., 48; termination, lysis 28th day; location, —; result, recovery; complications, nephritis; bacteriological ex., pneumococci; treatment, strych., digitalis.

Case 104—Age, 37; colored; max. temp., 101; pulse, 130; resp., 60; termination, died 24th day; location, both Bs; result, died; complications, nephritis; bacteriological ex., —; am. iodide, poultices.

Case 105—Age, 17; colored; max. temp., 104; pulse, 128; resp., 40; termination, lysis 24th day; location, —; result. recovery; complications, —; bacteriological ex., pneumococci, staph., nephritis; treatment, strych., amon. carb.

Case 106—Age, 27; colored; max. temp., 102; pulse, 110; resp., 28; termination, crisis 9th day; location, R. apex.; result, recovery; complications, —; bacteriological ex., —; treatment, strych., amon. chlor.

Case 107—Age, 21; colored; max. temp., 103; pulse, 110; resp., 28; termination, crisis 12th day; location, R base; result, recovery; complications, —; bacteriological ex., pneumococci; treatment, strych., amon. chlor., diuretics.

Case 108—Age, 38; colored; max. temp., 103; pulse, 115; resp., 40; termination, crisis 10th day; location L. base; result, recovery; complications, —; bacteriological ex., —; treatment, strych., poultices.

Case 109—Age, 26; colored; max. temp., 104; pulse, 132; resp., 48; termination, lysis 12th day; location, L. base; result, died; complications, —; bacteriological ex., —; treatment, strych., creosote carb.

Case 110—Age, 47; white; max. temp., 104; pulse, 106; resp., 34; termination, lysis 15th day, location, R. apex; result, recovery; complications, —; bacteriological ex., —; treatment, strych., am. carb.

Case 111—Age, 33; colored; max. temp., 103; pulse, 110; resp., 35; termination, crisis 2d day; location, R. base; result, recovery; complications, —; bacteriological ex., —; treatment, strych., am. chlor.

Case 112—Age, 38; colored; max. temp., 102; pulse, —; resp., —; termination, lysis 12th day; location, L. base; result, recovery; complications, —; bacteriological ex., —; treatment, strych., am. chlor.

Case 113—Age, 21; colored; max. temp., 106; pulse, 150; resp., 40; termination, died 3d day; location, L. base; result, died; complications, nephritis; bacteriological ex., —; treatment, strych., am. chlor., whiskey.

Case 114—Age, —; white; max. temp., 103; pulse, 108; resp., 28; termination, crisis 10th day; location, R. base; result, died; complications, endocardi.; bacteriological ex., —; treatment, strych., am. carb.

you are keeping under the boilers. Of course the greatest care must be observed in that feeling, as the least error or imprudence may cost you your patients' life; watch the moisture of the tongue, watch the action of the eliminative organs. To briefly review on the diet:

(a) Water *ad libitum;* (b) milk, peptonized or with vichy or lime water, lemonade or orangeade, imperial drink, malted milk, barley water, chicken tea, beef bouillon and butter milk; (c) no starches or sweets; (d) be careful of flatulence or hypotension, if constipation is produced change food accordingly; (e) fruits, oranges, grape-fruit, and grapes; (f) alcoholics used as a food, only when the heart flags, unless we are dealing with an alcoholic, and there is a wonderful tolerance of that food, this tolerance almost indicating nature's need for it. I prefer it given as milk punches or as Ducro's elixir or panopepton. (g) Return very slowly to solid food, wait until fever has all gone before you gradually return to general diet.

Second—The second most important factor in treatment is *rest*—absolute, continuous rest, the horizontal position all the time the pathological condition is going on, complete rest, in bed, and keep that up for a week after the crisis has taken place. Place the heart by this process, in a *sling as it were,* with as little additional work as possible upon it. Remember what this organ is doing during all the stages of this disease; the engorgement and distension of the right heart, and the failure of the right ventricle to propel the blood through the solidified lung tissues, and the great danger of toxaemia paralyzing the sympathetic, and accel-

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LOBAR PNEUMONIA.

Case 1—Age, 58; white; female; max. temp., 104; pulse, 104; resp., 42; location, —; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, strych, glyco. heroin, sps. ammonia; result, recovery.

Case 2—Age, 40; white, female; max. temp., no record; pulse, no record; resp., —; location, R. M. lobe; termination, crisis 10th day; complication, none; bacteriological ex., none made; treatment, cupping, calomel, sponging; result, recovery.

Case 3—Age, 42; colored, male; max. temp., no record; pulse, no record; location, R. U. M. and L. L.; termination, crisis 4th day, death; complications, hyperpyrexia; bacteriological ex., none made; treatment, cupping, calomel, ammonia, camphor, spartein, rectal douche; result, death.

Case 4—Age, 13; white, female; max. temp., no record; pulse, no reocrd; resp., no record; location, L. L. L.; crisis 5th day; complications, hyperpyrexia; bacteriological ex., none made; treatment, calomel, Dovers powder, strych., cold application, milk punch; result, recovery.

erating the inhibitory action of the vaso-motor. All this you avoid by *rest,* and you must watch for cyanosis, the tension of the pulse, its volume, and quickly interfere with medical agents. B. Solis-Cohen believes that there are three great causes for heart failure: (a) Toxæmia by auto-intoxication of the great centres; (b) the *mechanical obstruction* to the circulation in the lung causing over-burdening and dilatation, especially of the right heart; (c) by the alteration in the physical and chemical constitution of the blood, which, apart from the toxic effect (and the depression of the nervous and muscular system, *central* and *cardiac*) allow thereby ante mortem blood clot.

It is here that you must be a calm, competent and careful physicist; use digitalis, but all the time you are using it have a reason for its use, and when the slowing of the heart's action has taught you that you have given your patient enough of this drug, abandon it at once; a slow pulse is a safe pulse, and no digitalis; in a fast, hard bounding pulse, use purging, cupping, or blood-letting, but with a fast, soft, compressible pulse, always digitalis—

Case 5—Age, 38; white, male; septic chart; location, R. L. L.; termination, lysis 20th day; complications, abscess of lung; bacteriological ex., free of bact. tuberculosis; treatment, over elimination, ol. morrhuae, open air, exploration by trocar; result, recovery.

Case 6—Age, 58; colored, male; typical typhoid chart; location, R. L. L.; termination, lysis 3d week; complications, typhoid fever; bacteriological ex., free from bact. tuberculosis; treatment, strych., ammonia, cocaine, caffein, camphor oil, ar. senna; result, death.

Case 7—Age, 28; white, male; max. temp., no record; pulse, no record; resp., no record; location R. M. and L. L.; termination, lysis 15th day: complications, double; bacteriological ex., none made; treatment, strych., ammonia, cocaine, caffein, camphor oil, ar. senna; result, recovery.

Case 8—Age, 32; white, male; max temp., 105; pulse, no record; resp., no record; location, R. U. M. L. L.; termination, crisis 8th day; complications, pleurisy; bacteriological ex., none made; treatment, strych., ammonia, cocaine, caffein, camphor oil, ar. senna; result, recovery.

Case 9—Age, 8; colored; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, R. U. L.; termination, died 2nd day; complications, ac. meningitis; bacteriological ex., none made; treatment, caffein, baths, cold douche; result, death.

Case 10—Age, 45; white, male; max. temp., no record; pulse, no record; resp., no record; location, R. U. M. L.; termination, died 3rd day; complications, none; bacteriological ex., none made; treatment, caffein, camphor; result, death.

Case 11—Age, 40; white; male; max. temp., no record; pulse, no record; resp., no record; location, both lungs; termination, no record; complications, hemolytic jaundice, delirium; bacteriological ex., none made; treatment, leeches, strych.; result, death.

Case 12—Age, 14; white; female; max. temp., 104; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., cupping, quinine, calisaya elixir; result, recovery.

Case 13—Age, 17; white; male; max. temp., 104; pulse, no record; resp., no record; location, R. U. L.; termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., cupping, quinine, calisaya elixir; result, recovery.

use strychnin almost all through this second stage and third stage, use it almost as much as you used alcohol formerly—its consistent use has been one of the only redeeming features of meddlesome treatment. Nitroglycerin is a dangerous drug on account of its action on the centre governing the vaso motor. Use camphor either in 2 grs. powders with sugar of milk, or by deep hypodermatic doses of 1 to 3 minims worked with 10 minims of oil of sweet almonds, as I have frequently done with almost magic effect in some bad cases of profound cardiac depression. It is an ideal heart stimulant, leaving no bad effect afterwards. In cyanosis, by all means use atropin; it will have the happiest effect in relieving apnœa and supporting the heart. In the initial stages, if the heart is too fast and struggling to meet the overwork suddenly placed upon it, use a few doses of tr. aconite, veratrum viride or hyosciamus. I never use this latter group of should not say that of Norwood's tincture), and then I do not should not say that of Norwood's tincture), and then, I do not see what we want to accomplish with these agents that we can not do with other means at hand, i. e., skin, bowel and kidney elimination. Oxygen is a most valuable help to the heart, and in many very bad cases I have used it with splendid results.

Case 14—Age, 3; white; sex, no record; max. temp., 105; pulse, no record; resp., no record; location, R. U. L.; termination, died 5th day; complications, could not nourish; bacteriological ex., none made; treatment calomel, strych., cupping, calisaya elixir; result, death, sudden.

Case 15—Age, 17; white; male; max. temp., 105; pulse, no record; resp., no record; location, R. U. L.; termination, died 5th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., cupping, quinine, calisaya elixir; result, recovery.

Case 16—Age, 14; white; female; max. temp., no record; pulse, no record; resp., no record; location, R. U. L. and L.; termination, died 4th day; complications, emigrant train, double pneumonia; bacteriological ex., none made; treatment, serum, coffee by rectum; result, death.

Case 17—Age, 8; white; sex, no record; max. temp., 105; pulse, no record; resp., no record; termination, lysis 12th day; complications, double; bacteriological ex., none made; treatment, cold bath, packed to rectum, temp., great excitement, quinine and strych. by needle, Russel's Emuls. by mouth; result, recovery.

Case 18—Age, 65; colored; male; max. temp., 103; pulse, no record; resp., no record; location, R. L. lobe termination, lysis 6th day; complications, none; bacteriological ex., pneumococci, leucocytosis count 14,000; treatment, ice bag to lung, quin. strych., codein, iron, cresote; result, recovery.

Case 19—Age, 18; colored; male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 7th day; complications, ac. int. nephritis; bacteriological ex., pneumococci, leucocytosis count 15,000; result, recovery.

Case 20—Age, 20; colored; male; max. temp., 106; pulse, no record; resp., no record; location, C. pneum.; termination, crisis 8th day; complications, ac. bronchitis as sequela; bacteriological ex., pneumococci, leuco-cytosis, count 20,000; treatment, strych., sponge bath temp. 70, every three hours; result, recovery.

Third—Hyperpyrexia is the next consideration in my opinion; keep temperature down as much as possible at 103° or below. When it gets above that degree sponge or use ice bag to head. I must admit that I have never found a temperature which necessitated ice to the local spot of the lesion. When the temperature is not controlled by these methods I use cool high rectal enemas, and it generally has the desired effect—rarely use cold water in sponging, for you can get as good results from lukewarm water with a little alcohol or whiskey than from too much cold, and besides it does not chill as the other seems to do, and has a much pleasanter sensation. The coal tar group of agents must never be used in any stage of this disease, as the records are full of the fatalities caused by their excessive use. We must not place any more work on an over-burdened heart. Quinin is a much safer antipyretic. In high temperature with great nervousness, the bromides are safer also, producing sleep when it is most needed, and often reducing the blood tension, and in that way reducing temperature. I have used, when the patients' condition allowed it, and there were extremes of temperature, a combination of caffein cit., ext. nuc. vomica, phenacetin and sodium salicylate, and though I do not recommend this as routine practice, I am positive I have done

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Case 21—Age, 41; white; male; max. temp., 104; pulse, no record; resp., no record; location, double; termination, crisis 3rd day; complications, double influenza; bacteriological ex., none made; treatment, calomel, Norwood's veratrin, atropine, cold applications to head, lukewarm sponging, ducro, careful sputum contagion; result, recovery.

Case 22—Age, 58; white; male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., creosote, cotton batting jacket all through; result, recovery.

Case 23—Age, 60; colored; male; max. temp., 104; pulse, no record; resp., no record; location, L. L. L.; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., creosote, cotton batting all through; result, recovery.

Case 24—Age, 14; colored; female; max. temp., 104; pulse, no record; resp., no record; location, R. L. L.; termination, crisis 8th day; complication, none; bacteriological ex., none made; treatment, calomel, strych., creosote, cotton batting jacket all through; result, recovery.

Case 25—Age, 72; white female; max. temp., 103; pulse, 140; resp., 50; location, R. L. L. lobe; termination, lysis 10th day; complications, influenza; bacteriological ex. none made; treatment, strych., ammon. carb., panopepton, ducro; result, death.

Case 26—Age, no record; sex, no record; race, no record; max. temp., 104; pulse, no record; resp., no record; location, L. U. lobe; termination, crisis 5th day; complications, none; bacteriological ex., none made; treatment, strych., ammon., carb., panopepton, ducro; result, death.

The following series of 26 cases treated in the following way: 1. Calomel, epsom salts; 2 Quin. grains v, salol grs., 2 every 2 hours for 12 or 18 doses; 3 Pro nata strych. and whiskey, carb. of creosote and ammon. Light diet, liq. peptonoids, ventilated rooms, plenty water, warm applications locally poultices and antiphlogistine, cold sponge. For pain in respiration, plaster strips.

a great deal of good in this method. I never gave more than one or two doses and never more than 5 grains of phenacetin at a time. Robt. Liegel has treated 72 cases with sodium salicylate and has also found very good results from this method. In his experience it seems to retard the activity of the pneumococci, and neutralizes and eliminates the toxins.

Fourth—Pain. To control pain which is generally agonizing and sharp in the first stage, we must find some agent or means to give relief. It is generally much aggravated by cough or by deep inspiration, and is generally localized in the region of the nipple or the axilla of the affected side. Frequently I have controlled it entirely with strips of adhesive plaster, placed as you would plaster a fractured rib, immobilizing the affected side as much as possible. Blisters, of course, are also used, but should be set aside for many reasons, except in special cases—the turpentine stupes or mustard plaster has often a very delightful effect. In the young I either use a flaxseed poultice with oiled silk jacket,

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Case 27—Age, 60; race, no record; sex, no record; max. temp., 103; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 28—Age, 65; race, no record; sex, no record; max. temp., 105; pulse, no record; resp., no record; location, L. L. L.; termination, died 4th day; complications, none; bacteriological ex., none made; teatment as above; result, recovery.

Case 29—Age, 70; race, no record; sex, no record; max. temp., 104; pulse, no record; resp., no record; location, R. M. L.; termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 30—Age, 74; race, no record; sex, no record; max. temp., 104; pulse, no record; resp., no record; location, L. U. and L. L.; termination, died 5th day; complications, none; bacteriological ex., none made; treatment as above; result, recovery.

Case 31—Age, 14; race, no record; sex, no record; max. temp., 103; pulse, no record; resp., no record; location, L. L. L.; termination, no record; complications, none; bacteriological ex., none made; treatment as above; result, recovery.

Case 32—Age, 35; race, no record; sex, no record; max. temp., no record; pulse no record; resp., no record; location, R. U. L.; termination no record; complications, none; bacteriological ex., none made; treatment as above; result, recovery.

Case 33—Age, 42; race, no record; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, R. L. L.; termination, no record; complications, none; bacteriological ex., none made; treatment, as above; result, recovery.

Case 34—Age, 17; race, no record; sex, no record; max. temp., no record; pulse no record; resp., no record; location, L. L. L.; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment as above; result, recovery.

Case 35—Age, 28; race, no record; sex, no record; max. temp., 99; pulse, no record; resp., no record; location, L. L. L.; termination, no record; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 36—Age, 30; race, no record; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, L. L. L.; comulications, none; bacteriological ex., none made; treatment as above; result, recovery.

or after reddening skin thoroughly with either mustard or turpentine I envelope my little patient in a warm, thick coating of antiplogistine covered over with cotton packing. In spite of adverse criticisms this is a good practice, and it certainly has never done the patient any harm, and the patients unanimously claim the greatest comfort and ease from its use. We sometimes have to use opiates to relieve pain. When we do, let us always use it ourselves, either hypodermatically or by single doses, but never leave it in the hands of an untrained assistant, as it is of considerable danger. Use Dover's powders in the initiatory stage, or use a little codein in the last stage to relieve irritable cough and pain.

Fifth—To prevent complications, empyema, pericarditis, myocarditis and endocarditis, and to help the quicker resolution or the safe termination, we now come to the last classification or subdivision of indications for treatment which I thought I would recommend, and that is probably one of the most important.

Case 37—Age, 54; race, no record; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, L. U. and L. L.; termination, died 4th day; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 38—Age, 49; race, no record; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, L. U. and L. L.; termination, no record; comulications, none; bacteriological ex., none made; treatment as above; result, recovery.

Case 39—Age, 24; race, no record; sex, no record; max. temp., no record; pulse, no record; resp., no record; location, L. U. and L. L.; termination, no record; complications, none; bacteriological ex., none made; treatment, as above; result, recovery.

Case 40—Age, 32; white; male; max. temp., 104; pulse, no record; resp., no record; location, R. M. and L. L.; termination, lysis 14th day; complications, empyema; bacteriological ex., none made; treatment as above; resection 6th rib; result, imp.

Case 41—Age, 38; white; male; max. temp., 103; pulse, no record; resp., no record; location, R. M. and L. L.; termination, lysis 14th day; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 42—Age, 44; white; male; max. temp., 105; pulse, no record; resp., no record; location, L. L. L.; termination, lysis 12th day; complications, none; bacteriological ex., none made; treatment as above; result, death.

Case 43—Age, 41; white; male; max. temp., no record; pulse, no record; resp., no record; location, no record; termination, no record; complications, no record; bacteriological ex., none made; treatment as above; result, recovery.

Case 44—Age, 10; white; male; max. temp., no record; pulse, no record; resp., no record; location, no record; termination, no record; complications, no record; bacteriological ex., no record; treatment as above; result, recovery.

Case 45—Age, 6; no other records; treatment as above; result, recovery.

Case 46—Age, 9; no other records; treatment as above; result, recovery.

Case 47—Age, 3; no other records; treatment as above; result, recovery.

Case 48—Age, 8; no other records; treatment as above; result, death.

Case 49—Age, 10; no other records; treatment as above; result, death.

Case 50—Age, 5; no other records; treatment as above; result, death.

Case 51—Age, 18 mos.; no other records; treatment as above; result, death.

Case 52—Age, 7; no other records; treatment as above; result, recovery.

The *elimination* of the *toxin poisoning,* elimination by the skin, the bowels and the kidneys, attempt to throw out as quickly as possible the profound toxaemia which seems to have so quickly saturated the system. The skin and the bowels, the kidneys or the lymphatics are the main avenues through which this can be accomplished. Our patient is intensely poisoned and we want to help nature to destroy this poison, call it micrococcus, diplococcus, or what not. I begin this elimination at the start with a good calomel purge, followed generally by a saline purge, then I either use a hot mustard foot bath or a plain hot pediluvium; this starts the skin acting, and if the subject is in the first stage, I use, before consolidation has taken place, some caffein, phenacetin and sodium salicylate; the elimination is then continued through the emunctories. Putting him to bed well covered, and with uniform body temperature, keeps this up. Plenty of water to drink, vichy water or seltzer if preferable, and by this alkalinity the system is relieved through the kidneys of an ever-accumulating toxin. Flush the kidneys as it were, and help drainage. Free sponging, lukewarm sponging systematically will do this also, without counting on the happy effect on the temperature. High normal saline rectal

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Case 53—Age, 4; white, male; max. temp., 104; pulse, no record; resp., no record; location, L. lung; termination, crisis 5th day; complications, none; bacteriological ex., none; treatment, calomel, phenacetine, quin., ammon. chlor., turpentine; result, recovery.

Case 54—Age, 16; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. lung; termination, crisis 5th day; complications, none; bacteriological ex., no record; treatment, bromide, hypopor.; result, recovery.

Case 55—Age, 2; white, female; max. temp., 101; pulse, no record; resp., no record; location, R. lung; termination, crisis 9th day; complications, none; bacteriological ex., no record; treatment, bromide, hypophos.; result, recovery.

Case 56—Age, 5; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. lung; termination, crisis 5th day; complications, none; bacteriological ex., no record; treatment, bromide, hypopor; result, recovery.

Case 57—Age, 17; white, female; max. temp., 104; pulse, 145; resp., 50; location, R. L. lobe; termination, crisis 7th day; complications, none; bacteriological ex., no record; treatment, calomel, dovers powd., quin. hydrobromat, tr., gel. tr., tr. aconite; result, recovery.

Case 58—Age, 24; white, male; max. temp., 105; pulse, 140; resp., 40; location, R. M. L.; termination, crisis 9th day; complications; none; bacteriological ex., no record; treatment, liq. peptonoids; result, recovery.

Case 59—Age, 4; white, male; max. temp., 106; pulse, 130; resp., 50; location, R. U. M. & L.; termination, crisis 9th day; complications, meningitis; bacteriological ex., no pneumococci; treatment, strych., cold to head and heart, ammon. carb., cold sponging, nitroglycerine; result, recovery.

Case 60—Age, 21; white, male; max. temp., 104; pulse, no record; resp., no record; location, L. U. Con. lobe; termination, crisis 5th day; complications, typhoid fever 18th day, hemorr. 22d.; bacteriological ex., pneumococci; treatment, symptoms disappear after hemorrhage, cold sponging; result, recovery.

enemas at a temperature between 85 and 98 degrees, will do this to a marked degree also, besides strengthening patient.

All through this disease it is a safe course to use a few small triturates of calomel, followed by a small dose of sod. sulphate, for, besides the elimination, there is no better intestinal antiseptic than sulphate of soda and calomel. Large doses of iodide of potash, especially with the third stage, will eliminate the exudates and also help to throw out the accumulated pneumococci which seems

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Case 61—Age, 85; white, male; max. temp., 100; pulse, 120; resp., 30; location, R. L. lobe; termination, lysis 15th day; complications, emphysema rt. and lft. lungs; bacteriological ex., haugholm, 60 per cent, red B. C. 4,650,000,000, W. B. C., 6,800; treatment, heroin, digitalis, blister, ducros elix.; result, recovery.

Case 62—Age, 35; colored, male; max. temp., 104; pulse, 103; resp., no record; location, R. L. L. lobes; termination, crisis 7th day; complications, auterio scle.; bacteriological ex., pneumococci; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 63—Age, 20; colored, female; max. temp., 104; pulse, 135; resp., 30; location, R. U. M. & L. lobe; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 64—Age, 53; colored, female; max. temp., 103; pulse, 115; resp., 40; location, R. U. M. & L. lobe; termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 65—Age, 30; colored, male; max. temp., 103; pulse, 115; resp., 40; location, R. M. & L. L.; termination, crisis 8th day; complications going to Jesus; bacteriological ex., none made; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 66—Age, 2; colored, female; max. temp., 102; no pulse; resp., 60; location, R. & M. & L. L.; termination, no record; complications, none; bacteriological ex., none made; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 67—Age, 18; colored, male; max., temp., 104; pulse, 90; resp., 36; location, R. U. M. & L. lobes; termination, crisis 11th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., mustard, whiskey, ice bag head, cold water to drink; result, recovery.

Case 68—Age, 35; colored, male; max. temp., 100; pulse, 96; resp., 50; location, R. U. M. & L. lobes; poison accidentally; complications, none; bacteriological ex., none made; treatment, one dose by mistake, 8 1-2 tablets strych.; result, death.

Case 69—Age, 35; colored, female; max. temp., 100; pulse, 96; resp., 50; location, L. U. & L. lobes; termination, crisis 5th day; complications, none; bacteriological ex., none made; treatment, calomel, strych., ducro; result, recovery.

Case 70—Age, 22; colored, female, max. temp., 104; pulse, no record; resp., no record; location, L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, ammon., chlor., liq. ammon., acetate, ipecac, quin., acetanilid tablets; result, recovery.

Case 71—Age, 66; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; lysis 22d day; complications, influenza; bacteriological ex., none made; treatment, calomel, ammon., chlor., liq. ammon., acetate, ipecac, quin., acetanch tablets, also B. creosote, strych., morp., atropine, hypo.; result recovery.

Case 72—Age, 12; colored, male; max. temp., 105; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, calomel, ammon., chlor., liq. ammon., acetate, ipecac, quin., acetanch tablets, also B. creosote, strych., morp., atropine, hypo; result, recovery.

to be adherent to the mucous lining of the bronchial tubes and air cells. Chloride of ammonia and carbonate of ammonia, besides their effect on the heart, will have a beneficial effect also at this stage. Carbonate of creosote (beechwood) and creosotal, besides their strong antiseptic action, exert a very good eliminating effect and appear to me to be nearer being a *specific for this disease,* both by inhalation and by large continuous doses, than almost any other drug. Blood-letting has been practiced with very good results, and I proposed to use it last winter, but did not have any case which I thought justified it. It seems to be very logical in the second stage when there is cyanosis or the right heart is labor-

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Case 73—Age, 60; colored, male; max. temp., 103; pulse, no record; resp., no record; location, R. L. lobe; termination, lysis 12th day; complications, none; bacteriological ex., none made; treatment, calomel, ammon., chlor., liq. ammon., acetate, ipecac, quin., acetanch tablets, also B. creosote, strych., morp., atropine, hypo; result, recovery.

Case 74—Age, 56; white, female; max. temp., 103; pulse, no record; resp., no record; location R. L. lobe; termination, died 7th day; complications, double; bacteriological ex., none made; treatment, morph., quin., dovers powder; result, death.

Case 75—Age, 50; white, male; max. temp., 103; pulse, no record; resp., no record; location, R. M. lobe; termination, lysis 14th day; complications, none; bacteriological ex., none made; treatment, gelsemium, antikam., ammon. carb.; result, death.

Case 76—Age, 50; colored, female, max. temp., 103; pulse, no record; resp., no record; location, L. L. lobe; termination, lysis 15th day; complications, none; bacteriological ex., none made; treatment, turpentine by mouth, antifebrine.

Case 77—Age, 76; white, male; max. temp., 102; pulse, no record; resp., no record; location, R. & L. U. L.; termination, died 5th day; complications, arterio sclero; bacteriological ex., none made; treatment, turpentine by mouth, antifebrine, strych.; result, death.

Case 78—Age, 25; white, female; max. temp., 103; pulse, no record; resp., no record; location, R. L. lobe; termination, lysis, 10th day; complications, none; bacteriological ex., none made; treatment, castor, gelsemium, antikamnia, ammon., carb.; result, recovery.

Case 79—Age, 18; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, castor, gelsemium, antikamnia, ammon., carb.; result, recovery.

Case 80—Age, 35; white, male; max. temp., 105; pulse, no record; resp., no record; location, R. L. lobe; termination, lysis 15th day; complications, none; bacteriological ex., none made; treatment, blister, gelsemium, antikamnia, chloral, brom., dovers powder, strych.; result, death.

Case 81—Age, 67; white, female, max. temp., 103; pulse, no record; resp., no record; location, L. L. lobe; termination, died 4th day; complications morphomania; bacteriological ex., none made; treatment, digitalis, castor oil; result, death.

Case 82—Age, 3; white, male; max. temp., 103; pulse, no record; resp., no record; location, L. U. lobe; termination, lysis 14th day; complications, none; bacteriological ex., none made; treatment, calomel, ipecac, quin., ammon. carb., Squill's turp. ex.; result, recovery.

Case 83—Age, 84; white, male; max. temp., 102; pulse, 120; resp., 36; location, R. U. M. & L. L. lobes; termination, died 11th day; complications, none; bacteriological ex., none made; treatment, strych., codein sulph., turpentine stupes, ducro; result, death.

Case 84—Age, 17; white, male; max. temp., 104; pulse, 130; resp., 36; location, L. U. & L. L. lobes; termination, lysis 9th day; complications, ac. pleurisy and malaria; bacteriological ex., none made; treatment, calomel, quin., ainum hypoder, salol, bismuth; result, recovery.

ing so hard and the nervous system is also endeavoring so hard to propel the blood through the lungs; there does not seem to be any kind of danger in its practice, specially in the robust and the plethoric. In the third stage, if there is profound narcosis with great absorption of septic and toxaemic substances, I do not see why we could not also, after blood-letting, and after having relieved the tension of the vessels and the struggle of the right heart, throw in the circulation half the volume withdrawn, of normal saline solution carefully and slowly, to first strengthen the heart and also principally to act as a diluent for the poisonous organisms in the blood.

As all alcoholics invariably do badly with pneumonia, one of the good treatments would be, by prophylaxis, to diminish alcoholism.

I am perfectly convinced of the infectiousness of pneumonia, so I believe we should observe considerable precaution. We should segregate our cases, air the rooms freely and frequently, destroy

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Case 85—Age 56; white, female; max. temp., 103; pulse, 125; resp., 34; location, R. M. & L. L.; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, calomel, quin., ainum hypoder, salol, bismuth; result, recovery.

Case 86—Age, 17; white, male; max. temp., 105; pulse, no record; resp., no record; location, L. M. & L. lobes post; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, calomel, quin., Ai-num hypoder, salol, bismuth; result, recovery.

Case 87—Age, 16; white, female; max. temp., 104; pulse, 140; resp., 50; location, R. W. lobe; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, calomel, quin., Ai-num hypoder, salol, bismuth, also creosote 7 drops; result, recovery.

Case 88—Age, 18; white, male; max. temp., 104; pulse, no record; resp., no record; location, L. U. & L. lobes; termination, crisis 8th day; complications, malaria; bacteriological ex., none made; treatment, calomel, quin., Ai-num hypoder, salol, bismuth; result, recovery.

Case 89—Age, 1; white male; max. temp., 102; pulse, 140; resp., 60; location, L. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, quin., Ai-num hypoder, salol, bismuth, also big doses quin.; result, recovery.

Case 90—Age, 54; white, female; max. temp., no record; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment, creosote, carb., digitalis; result, recovery.

Case 91—Age, 50; white, male; max. temp., no record; pulse, no record; resp., no record; location, R. U. lobe; termination, crisis 9th day; complications, none; bacteriological ex., none made; creosote, carb., digitalis; result, recovery.

Case 92—Age, 2; white, male; max. temp., 104; pulse, 150; resp., 60; location, R. M. & lobes; termination, crisis 8th day; complications, none; treatment, creosote, carb., digitalis; result, recovery.

Case 93—No records; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, creosote, carb., digitalis; result, recovery.

Case 94—No records; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, tepid water, sponging, ammon., chlor.; result, recovery.

Case 95—No records; termination, lysis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, hyoscin, strych., digitalis.

all sputum, have all clothing and bed linen washed, boiled separately from the balance of the washing, and do not allow the clothes contact with the well. I have had five instances of infection, two of which took place in my own family.

Dr. Galbraith, in a recent report in the *A. M. J.*, has given out history of fifty cases treated with quinin, large initial doses, specially without one fatality. We should all try such excellent results.

The compilation from cases at the Charity Hospital, furnished me by the kind courtesy of the House Surgeon, Dr. J. M. Batchelor, and which was gotten up by Dr. W. T. Richards, reached me only yesterday morning, so I have not had time yet to properly tabulate the results.

Case 96—Age, no record; max. temp., 104; pulse, 120; resp., 44; location, L. L. lobe; termination, crisis 5th day; complications, none; bacteriological ex., none made; treatment, aconitine, strych., arom. chlor.; result, recovery.

Case 97—Age, 25; white, female; max. temp., 104; pulse, no record; resp., no record; location, R. U. L.; termination, died 10th day; complications, tuberculosis; bacteriological ex., none made; treatment, strych., turpen., stupes; result, death.

Case 98—Age, 18 mos., colored; max. temp., no record; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 5th day; complications, none; bacteriological ex., none made; treatment, turpentine and poultices; result recovery.

Case 99—Age, 25; colored, male; max. temp., 105; pulse, no record; resp., no record; location, R. U. M. & L. L., termination, crisis, 18th day; complications, none; bacteriological ex., none made; treatment, also carb. of creosote; result, recovery.

Case 100—Age, 4; colored; max. temp., 103; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis 5th day; complications, none; treatment, also carb. of creosote; result, recovery.

Case 101—Age, 3; colored, male; max. temp., 105; pulse no record; resp., no record; location, R. M. L; termination, crisis 8th day; complications none; treatment, also carb. of creosote; result, recovery.

Case 102—Age, 2; colored; no records; termination, crisis 10th day; complications, none; treatment, calomel, ipecac; result, recovery.

Case 103—Age, 3; colored; no records; location, L. & R. L. L. lobes; termination, lysis 15th day; complications, influenza; treatment, creosotal every 2 or 4 hours, creosoteal 20 drops 2 or 4 hours; result, recovery.

Case 104—Age, 24; colored, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. & L. post; termination, crisis 5th day; complications, none; bacteriological ex., none made; treatment, mustard sides, dovers powders; result, recovery.

Case 105—Age, 32; colored, male; max. temp., 104; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis 4th day; complications, none; bacteriological ex., none made; treatment, calomel, acetanelid, caf.; result, recovery.

Case 106—Age, 40; colored, male; max. temp., 105; pulse, no record; resp., 48; location, L. & R. L. lobes; termination, crisis 8th day; complications, double; bacteriological ex., none made; treatment, creosote as specific; result, recovery.

Case 107—Age, 50; white, female; max. temp., 102; pulse, no record; resp., no record; location, R. M. M. & L.; termination, crisis 5th day; complication, none; bacteriological ex., none made; treatment, creosote as specific; result, recovery.

Case 108—Age, 30; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, calomel, salts, small blister, dovers powders, codein, strych.; result, recovery.

It is made up of cases taken only this winter, and consists of:

No of cases	112
No. of cases (white)	58
No. of cases (colored)	52
No. of deaths	34
Percentage of mortality	30.3%
No. of cases of deaths (whites)	20
Percentage of mortality with whites	34.5%
No. of cases of deaths (colored)	14
Percentage of mortality with colored	26.9

AGES.

Less than 10 years of age	5 cases	1 died	20 %
Between 10 yrs. and 60 yrs. of age	101 "	30 "	29.7%
Over 60 yrs. of age	6 "	3 "	50 %

This will be finished later, as it will be a highly interesting comparison to draw of differences between the experience of general practice in the country, in the city and in the hospital. Outside of the bad hygiene of ordinarily crowded hospital wards, it is not quite a fair comparison, as nearly all the cases admitted to the hospital are over the first stage and so far advanced that they are not a proper test for treatment.

Case 109—Age, 30; white, male; max. temp., 105; pulse, 88; resp., 24; location, L. L. lobe; termination, crisis 6th day; complications, none; treatment, sponging, ice bag, bed one week; result, recovery.

Case 110—Age, 32; white, male; max. temp., 105; pulse, no record; resp., no record; location, L. L. lobe; termination, dies on 3d day; complications, chr. alcoholism; bacteriological ex., none made; treatment, tr. aconite, panopepton; result, death.

Case 111—Age, 7; white, male; max. temp., 105; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis, 21st day; complications, empyema res.; bacteriological ex., pus full pneumococci; treatment, resection of rib; result, recovery.

Case 112—Age, 3; white, female; max. temp., 104; pulse, no record; resp., no record; location, L. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment as 107–110; result, recovery.

Case 113—Age, 5; white, male; max. temp., 105; pulse, no record; resp., no record; location R. M. lobe; termination, lysis 18th day; complications, none; bacteriological ex., none made; treatment, small doses calomel, phenacetine, nux vom. ex., quinine; result, recovery.

Case 114—Age, 17; white; max. temp., 103; pulse, no record; resp,, no record; location, R. M. L.; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, mustard plas., ammon.; result, recovery.

Case 115—Age, 30; white, female; max. temp., 102; pulse, no record; resp., no record; location, L. L. L.; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, mustard plas.; result, recovery.

Case 116—Age, 4; white, female; max. temp., 105.; pulse, no record; resp., no record; location, R. M. & L. L. L.; termination, lysis 23d day; complications, convulsions; bacteriological ex., none made; treatment, mustard plas; result, recovery.

DISCUSSION OF PAPER ON PNEUMONIA BY DR. LEBEUF.

DR. JONES.—I want to thank Dr. LeBeuf for the interest and care he has taken in collecting these statistics. Dr. LeBeuf gave the pathology, and then spoke of the ulceration, and he spoke of the probability of pneumonia being a germ disease. It very probably is a germ disease, and forms an antitoxin, and this antitoxin must be very limited in its effects or very local. By local I mean central in the parts of the lungs which are involved. In these inflamed tissues are numerous white blood groups, and few

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Case 117—Age, 55; white, female, max. temp., 103; pulse, no record; resp., no record; location, R. M. lobe; termination, died on 8th day; complications, alcoholism, chr. nephritis; bacteriological ex., none made; treatment, no antipyretic; result, death.

Case 118—Age, 54; white male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, no antipyretic; result, recovery.

Case 119—Age, 29; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. lobe, termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment, no antipyretic; result, recovery.

Case 120—Age 20; max. temp., 105; pulse, no record; resp., no record; location, R. U. L.; termination, lysis 16th day; complications, none; bacteriological ex., none made; treatment, no antipyretic; result, recovery.

Case 121—Age 60; white, male; max. temp., 102; pulse, no record; resp., no record; location, L. L. & R. M. lobes; termination, died on 30th day; complications, none; bacteriological ex,, none made; treatment, no antipyretic; result, death.

Case 122—Age, 33; white, male; max. temp., 105; pulse, no record; resp., no record; location, R. M. lobe; termination, died on 21st day; complications, delirium tremens; bacteriological ex., none made, treatment, no antipyretic; result, death.

Case 123—Age, 17; white, male; max. temp., 104; location, L. U. L.; termination, lysis 10th day; complications, N has tubercu.; bacteriological ex., none made; result, recovery.

Case 124—Age, 8; white, female; max. temp., 103; pulse, no record; resp., no record; location, R. M. L.; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, no antipyretic; result, recovery.

Case 125—Age, 4; white, male; max. temp., 103; pulse, no record; resp., no record; location, R. M. L.; termination, lysis 16th day; complications, pertussis; bacteriological ex., none made; treatment, none; result, death.

Case 126—Age, 20; white, male; max. temp., 106; pulse, no record; resp., no record; location, R. U. — L. L. lobe; termination, died on 8th day; complications, child birth (septicaemnia); bacteriological ex., none; treatment, none; result, death.

Case 127—Age, 10; white, male; max. temp., 104; pulse, no record; resp., no record; location, R. L. L.; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, none; result, recovery.

Case 128—Age, 30; white, male; max. temp., 103; pulse, no record; resp., no record; location, R. M. L.; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, none; result, recovery.

Case 129—Age, 30; white, female; max. temp., 104; pulse, 112; resp., 42; location, R. L. L.; termination, crisis 6th day; complications, labor; bacteriological ex., none made; treatment, calomel, quin., ducro, ecthol, ammon., carb., strych., peptonoids, creosote; result, recovery.

Case 130—Age, 24; colored, male; max. temp., 104; pulse, 120; resp., 48; location, R. M. & L. lobes; termination, lysis 11th day; complications, malaria; bacteriological ex., none made; treatment, calomel, quin., ducro., ecthol, ammon., carb., creosote; result, recovery.

red blod corpuscles. We find that the red blood corpuscles have mostly disappeared. The lung may increase in weight from one to three pounds in pneumonia. Dr. LeBeuf also brought out that the clinical crisis is not concomitant with the repair of the lung. There is an exude which must be removed.

Dr. Mueller has done considerable work in this line with Dr. Simon, of Mobile. They took portions of a hepatized lung and immersed same in tural water, which has no power on the action of the ferments. They found that in from one to five days the hepatized lung became soft, and to the touch was like the natural

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Case 131—Age, 22; colored, male; max. temp., 103; pulse, 100; resp., 40; location, R. M. lobe; termination, lysis, 9th day; complications, smallpox; bacteriological ex., none made; treatment, creosote 20m. every four hours; result, recovery.

Case 132—Age, 45; colored, male; max. temp., 103; pulse, 100; resp., 40; location, R. M. lobe; termination, lysis 8th day; complications, sup. otitis, iritis; bacteriological ex., inf. from son died of pneumo.; treatment, creosote, 20M every four hours; result, recovery.

Case 133—Age, 12; colored, female; max. temp., 105; pulse, 130; resp., 42; location, L. L. lobe; termination, crisis 6th day; complications, none; bacteriological ex., inf. from father; treatment, creosote 20M every four hours; result, recovery.

Case 134—Age, 28; colored, female; max. temp., 104; pulse, 120; resp., 40; location, R. L. L.; termination, —; complications, none; bacteriological ex. none made; treatment, creosote 20M every four hours; result, recovery.

Case 135—Age, 35; colored, male; max. temp., 104; pulse, 100; resp., 38; location, R. L. L.; termination, lysis 16th day; complications, malaria; bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 136—Age, 18; colored; male; max. temp., 103; pulse, 110; resp., 70; location, R. M. and L. lobes; termination, died 10th day; complications, none; bacteriological ex., none made; treatment, quin. sulph. 10 grs.; result, death.

Case 137—Age, 7; colored; male; max. temp., 104; pulse, 125; 38; location, R. L. L.; crisis 8th day; complications none, bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 138—Age, 16; white; male; max. temp., 103; pulse, 96; resp., 38; location, R. L. L.; termination, crisis 6th day; complications, none bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 139—Age, 19; white; female; max. temp., 103; pulse, no record; resp., no record; location, L. L. L.; termination, crisis 7th day; complications, none; bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 140—Age, 35; colored; male; max. temp., 104; pulse, 110; resp., 48; location, R. and L. L. lobes; termination, lysis 20th day; complications, double; bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 141—Age, 50; white; male; max. temp., 105; pulse, no record; resp., 40; location, L. U. L. L. L.; termination, lysis 10th day; complications, none; bacteriological ex., none made; treatment, quin. sulp. 10 grs.; result, recovery.

Case 142—Age, 24; white; male; max. temp., 104; pulse. no record; resp., no record; location, R. M. and L. and L. L.; termination, died 12th day; complications, blood clot (heart); bacteriological ex., none made; treatment, calomel, antiphlo., ammon., chlor., bromo elx., May pops, strych., nitro-glycerine; result death.

Case 143—Age, 20; white; female; max. temp., 102; pulse, no record; resp., no record; location, R. L. L.; termination, crisis 8th day; complications, none; bacteriological ex., none made; treatment, calomel, antiphlo., ammon. clor., bromo elx., May pops, strych., nitro-glycerine; result, recovery.

lung. They founnd that the fibrin was dissolved and that the red blood corpuscles disappeared. They tested this local mass and found albuminosis, and the longer they allowed this mass to remain, the more evenly were assimilated the products of pancreatic digestion in the stomach. In this lung, with which they were experimenting, they found that it had the power of auto-digestion, and I very strongly believe that in the various organs of the body we have the ability to digest, and that there is digestion going on all the time. This is of exceeding interest, because we

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Case 144—Age, 17; white; male; max. temp., 103; pulse, no record; resp., no record; location, R. M. L.; termination, crisis 9th day; complications, none; bacteriological ex., none made; treatment, calomel, antiphlo., ammon. clor., bromo elx., May pops, strych., nitro-glycerine; result, recovery.

Case 145—Age, 45; white; male; max. temp., 104; pulse, no record; resp., no record; location, R. M. and L. L.; termination, crisis 10th day; complications, none; bacteriological ex., none made; treatment, calomel, antiphlo., ammon. clor., bromo elx., May pops, strych., nitro-glycerine; result, recovery.

Case 146—Age, 4 months; colored; female; max. temp., 102; pulse, 160; resp., 60; location, R. L. M. and L.; termination, lysis 2nd day; complications, none; bacteriological ex., none made; treatment, injections creosote calcicum, iodide, ducro; result, recovery.

Case 147—Age, 3; white; male; max. temp., 102; pulse, 140; resp., 60; location, L. U. and L. L. lobe; termination, no record; complicaitons, empyema; bacteriological ex., none made; treatment, calomel, sulph, carbonat ammon, operation; result, recovery.

Case 148—Age, 21; white; male; max, temp., 105; pulse, 136; resp., 44; location, R. L. lobe; termination, crisis 5th day; complications, syphilis; bacteriological ex., none made; treatment, caffein, phenacetin, strych., poultices, antiphlogistine, alcoholics on 4th day; result, recovery

Case 149—Age, 20; white; male; max. temp., 105 2-5; pulse, 150; resp., 46; location, R. M. L.; termination, crisis 4th day; complications, none; bacteriological ex., none made; treatment, caflein, phenacetin, strych., poultices, antiphlogistine, alcoholics 4th day; result, recovery.

Case 150—Age, 32; white; male; max. temp., 105; pulse, 140; resp., 46; location, R. M. and L. L.; termination, crisis 5th day; complications, ac. pleurisy; bacteriological ex., none made; treatment, caffein, phenacetin, strych., poultice, antiphlogistine, alcoholics on 4th day and adhesive strips; result. recovery.

Case 151—Age, 7; white, male; max. temp., 105; pulse, 130; resp., 44; location, R. M. L.; termination, crisis 4th day; complications, whooping cough; bacteriological ex., none made; treatment, ammon., chloride, digitalis, mustard, cool enemas; result, recovery.

Case 152—Age, 8 months; white, male; max. temp., 106; pulse, 160; resp., 80; location, R. L. U.; complications, pertussis; bacteriological ex., none made; treatment, mustard, cool enemas, antiphlogistine; result, recovery.

Case 153—Age, 74; white; male; max. temp., 103; pulse, 112; resp., 40; location, L. U. L.; termination, lysis 9th day; complications, pleuritic effs'n; bacteriological ex., Pfeif., pneumococci; treatment, cal., strychnia, alcohol; result, recovery.

Case 154—Age 3 months; white, female; max. temp., 104; pulse, 140; resp., 50; location, R. L. L.; termination, lysis 8th day; complications, none; bacteriological ex., none made; treatment, mustard, antiphlogistine, ammonia, stimulation; result, recovery.

Case 155—Age, 4; white; female; max. temp., 104; pulse, 120; resp., 40; location, R. M. L.; termination, crisis 6th day; complications, none; bacteriological ex., none made; treatment, ammonia, chlor., plaster strips, quinine, calomel; result, recovery.

Case 156—Age, 66; white; male; max. temp., 105; pulse, 120; resp., 46; location, L. U. and R. L.; termination, lysis 14th day; complications, la grippe and mitral disease of heart; bacteriological ex., Pfeif., pneumo.; treatment, strych., codein, nitro.; result, recovery.

find that this exudate has got to be liquified, and no other theory gives us an explanation of the liquification of the exudate. The anti-toxic effect produced by the life of the germ producing pneumonia, to my mind, consists of a part of one cycle of a two-cycle effect. The germ produces an exudate and also produces its own destruction. Then the white blood cells bring to bear their ferment to act upon and digest this exudate, and it is carried off by the leucocytes. It has been shown that a man will eliminate what would be equivalent to about 28 grams of the pneumonia exudate. How it is eliminated I do not know.

The only thing that I wanted to particularly bring out was that the experiments conducted by Simon and Mueller were on por-

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Case 157—Age, 5; white, male; max. temp., 104; pulse, 112; resp., 36; location, R. M. & L.; termination, lysis 10th day; complications —; bacteriological ex., —; treatment, glycerine, mustard and antiphlogistine; result, died.

Case 158—Age, 70; white; male; max. temp., 105; pulse, 160; resp., 60; location, L. R. & L.; termination, lysis 3d day; complications, mitral-aortic; bacteriological ex,, Pfeif., pneumo., dis. streptococci; treatment, ammonia, digitalis, strych., atropine, nitro-glycerine, oxygen, blister; result, died.

Case 159—Age, 76; white; female; max. temp., 103; pulse, 140; resp., 66; location, R. L. L.; termination, lysis 5th day; complications, influenza; bacteriological ex., strep., staphylococci; treatment, ammonia, chlor., strych., digitalis, mustard, antiphlogistine, alcohol; result, died.

Case 160—Age, 64; white; male; max. temp., 104; pulse, 118; resp., 34; location, R. L.; lysis 9th day; complications, asthma; bacteriological ex., pneumococci; treatment, codeine, ammonia chlor., tr. digitalis, strych.; result, recovery.

Case 161—Age, 32; white; female; max. temp., 103; pulse, 120; resp., 32; location, R. L.; termination, lysis 7th day; complications, none; bacteriological ex., pneumococci; treatment, alcohol, mustard, antiphlogistine; result, recovery.

Case 162—Age, 11; white; male; max. temp., 105; pulse, 140; resp., 50; location, R. L. L.; termination, lysis 15th day; complications, pertussis; bacteriological ex., none made; treatment, Ducro, ammonia, chlor., mustard, petroleum, antiphlogistine; result, recovery.

Case 163—Age, 24; white; female; max. temp., 106; pulse, 160; resp., 60; location, R. M. L.; termination, lysis 22d day; complications, tuberculosis; bacteriological ex., pneumococci, bac. tuberc.; treatment, oxygen, creosotal, mustard, antiphlogistine, blister, plaster strips, strych., atropine, digitalis, alcoholics—still under Dr. Durel—tubercular 22 lbs. imp.; result, recovery.

Case 164—Age, 12; white; male; max. temp., 105; pulse, 120; resp., 36; location, R. L.; termination, lysis 6th day; complications, none; bacteriological ex., none made; treatment, codein, quinine, ammonia chlor., mustard, stimulants; result, recovery.

Case 165—Age, 22; white; male; max. temp., 104; pulse, 124; resp., 38; location, L. L. L.; termination, lysis 12th day; complications, none; bacteriological ex., pneumococci; staphylococci; treatment, mustard plaster, strips, codein, digitalis, ammonia chlor., calomel, quinine; result, recovery.

Case 166—Age, 35; white; female; max. temp., 106; pulse, 172; resp., 60; location, R. M. L.; termination, lysis 14th day; complications, ac. par nephritic; bacteriological ex., negative; treatment, salol, caffein, calomel, codein; result, recovery.

Case 167—Age, 44; white; male; max. temp., 103; pulse, 110; resp., 30; location, R. M. L.; termination, lysis 7th day; complications, ac. meningitis; bacteriological ex., none made; treatment, caffein, phenacetin, salol, strych., codein, mustard, antiphlogistine; result, recovery.

tions of lung that were absolutely sterile, and were rendered so through a course of sterilization lasting eleven days, so that no germ had anything to do with the digestive processes. They made cultures of agar-agar and beef broth, and microscopic examination shows no bacteria. We also know that double cases of pneumonia do not have the power of converting albumens into albuminosis. When this material was allowed to remain in the incubator for any time, they found products of digestion which would, in all probability, not be found in the living subject.

DR. E. M. DUPAQUIER, New Orleans: I congratulate the Doctor on the selection of the subject for discussion, since pneumonia, like tuberculosis and cancer, is a problem for us to solve. I congratulate him on the labor shown in his paper, but I have a few remarks and comments to make about some of his views, and will ask to make them freely.

As to the statistics he has produced, I think they are not of any value, no more than other statistics covering a limited number of cases. We can draw conclusions, if any, only from large hospital statistics covering thousands and tens of thousands of cases, not only from one hospital, but from many, taking into consideration, as Preble says, the fact that disease, as seen in hospitals, is much more than as seen in family practice.

Regarding the progress in treatment, I am opposed to the statement that some has been made. We have no specific. The best we can do is to have a clear conception of the morbid process, the toxæmia, and help the organism to hold out. We can do so by using freely calomel, dry cups, and in the main, cold applications. Strychnin in increasing doses, supplemented by caffein and cocain will maintain the nervous tone aroused by cold applications and, as a consequence, free diuresis, which is capital. The best renal

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Case 168—Age, 5; white; female; max. temp., 104; pulse, 124; resp., 40; location, R. L. L.; termination, lysis 6th day; complications, ac. pleurisy; bacteriological ex., none made; treatment, ammon., chlor., mustard, antiphlogistine, calomel, stimulation, sponges warm; result, recovery.

Case 169—Age, 18; white; female; max. temp., 104; pulse, 160; resp., 60; location, R. L. L.; termination, lysis 12th day; complications, double; bacteriological ex., none made; treatment, ammon., chlor., mustard, antiphlogistine, calomel, stimulation, sponges warm; result, recovery.

Case 170—Age, 48; white; male; max. temp., 105; pulse, 180; resp., 60; location, R. U. M. & L., & L. L. L.; termination, lysis 10th day; complications, double; bacteriological ex., pfeif. pneumo.; treatment, ammon,, chlor., mustard, antiphlogistine, calomel, stimulation, sponges warm; **result, death.**

stimulant, as Musser says, is *water* in large amounts, a total quantity of 2 to 3 quarts in the 24 hours. The daily amount of urine falling below 30 ounces, salt solution in a pint or quart dose should be injected in the rectum and, if not followed by improvement, under the skin. Ammonium and alcohol are used as reinforcements—chiefly the latter, when in extraordinary cases we want to tide the patient over a critical period (Musser). It is not good to give alcohol in ordinary cases, to those who are not accustomed to it (Preble). As regards failure of the circulation when the blood pressure is low, I prefer the soluble digestion by needle than digitalis by mouth in conjunction with a small bleeding early in the course of the disease, followed by injection of salt solution under the skin.

I object to cough measures, and use codein only when the coughing aggravates pain and consequently delirium. In those who have abundant mucus in the bronchi, as in old people, *atropin* is indicated. I do not like the small dose of calomel suggested by the Doctor as intestinal antiseptic. Tympany, a serious sign, is better met with purgation, turpentine or eserin by needle.

Summing up rapidly, I stand on the following requisites for treatment: exclusion of routine and of so-called specifics, good nursing, little drugging, cold applications, substantial diet, rest and sleep. I do not think there are two teachers on practice in this country who have more assisted the practitioner in treating pneumonia and pneumococcus infections than Musser and Preble,

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Results of tabulation were made and percentage taken only in 170 cases taken from private practice, as Charity Hospital were not fair test.

This is the result of cases taken at large from the city and country practice:

Cases	170
Recovered	138
Died	32
Percentage	18.81%

Five instances of infection from one member of a family to another, generally a close attendant, in close contact.

One instance of triple infection from daughter to father, and from the father to another child.

One instance where the infection from the daughter to the mother in attendance, took place in 36 hours.

Three cases developed into empyema and were operated on and recovered.

Two cases had pleuritis effusion and were tapped.

Whenever the cases were mixed with influenca bacillus, or had streptococci and staphlococci in excess, or malaria, or some other intercurrent condition they generally finished by lysis. Invariably in **our state,** when the deferescence was slow, or there seemed to be a recrudescence of symptoms, this was controlled generally by big doses of quinine.

and the views of both on the subject I am glad to champion in my limited sphere. Of course, when taking the attitude of advocating strongly *cold* applied in no half-hearted way, I do not discard hot applications altogether. These are better than cold in cases of slow resolution, late in the course of the disease, and in conjunction with them I favor the hypodermic use of turpentine at that stage, according to Fochier's practice, to bring about the formation of an abscess. In my report of cases to the chairman, I have mentioned the good result following abscession. Regarding solution, Dr. Jones has reported very interesting facts. As a matter of local record, before this same Society, I well recall that Dr. Batchelor was the first to report on the use of ice bags in the treatment of pneumonia, some few years ago.

Dr. Watson: It is refreshing to listen to these papers. We seem to have two distinct views here, and they are probably both right.

STATISTICAL RECAPITULATION.

Mortality by age.	Cases.	Deaths.	Per Ct.
Under 10 years of age	42	6	10.4%
Between 10 years and 60 years	103	19	18.4%
Over 60 years	19	7	30.6%
No record of age	6	..	.....
Race, colored	38	6	16.04.%

Sex—male, 104; female, 34; no record, 29; No. deaths, 7; per cent., 20.05.

Location one lobe above.	Frequency.	Mortality.
Right upper lobe	8	2
Right middle lobe	21	1
Right lower lobe	38	2
Left upper lobe	5	0
Left lower lobe	28	5
Central Pneumonia	2	2
Two lobes or more, same lung.		
Right, upper, middle and lower lobes	8	8
Right, middle and lower lobes	8	2
Left, upper and lower lobes	15	15
Location—Double Pneumonia, two or more lobes affected in separate lungs.		
Right, upper, middle and lower and left lower lobes	4	2
Right, mdidle, lower and left lower lobes	8	1
Right and left lower lobes	9	2
Right, upper anl lower and left lobes	4	1
Right and left upper lobes	1	1
No record or location in 44 cases.		
Right, upper and left lower lobes	1	1

Right lung affected, 110; left lung affected, 50; no record in 10.

Mortality of right lung alone	21
Mortality of right lung, one lobe	5
Mortality of right lung, two lobes	2
Mortality of right lung, three lobes	8
Mortality of left lung alone	20
Mortality of left lung, one lobe	5
Mortality of left lung, two lobes	15
Mortality of right and left lungs, two lobes	4
Mortality of right lung, two lobes	2
Mortality of right lung, three lobes	2

The diagnosis is usually easy. A temperature of 105 or near that will indicate a severe case. The prognosis is not based upon the condition of your patient. If you have a young child or a very old person, the prognosis is bad; or, if you have a man with Bright's disease, or if you have an alcoholic or a person who has suffered with delirium tremens, they are all bad, but cases of pneumonia without these complications, the prognosis is not bad.

Now, statistics always tell the truth. If we doctor them they are not good. Of course, in a short paper like this, the Doctor could not go into the details of all the cases of pneumonia.

Now, as to the line of treatment in pneumonia, they are both of them right in some cases, and in some particulars both of them are wrong. We have to use a great deal of judgment in treating pneumonia. We have a great deal of horse sense.

If I were a doctor having a hospital practice I would adopt Dr. LeBeuf's treatment in full, but when we are called upon to treat cases under other conditions, we must adapt our treatment to the

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CASES TERMINATED.

Crisis	83
Lysis	33
No record	51

	Complications,	Death.
Hyperpyexia	1	1
Abscess of lung	1	
Typhoid fever	2	1
Double	6	2
Ac. Pleurisy	4	
Ac. Meningitis, convulsions	4	1
Haemylotici Jaundice, delirium	1	1
Ac. Int. Nephritis	2	1
Ac. Bronchitis	1	
Influenza	7	3
Empyema	3	
Hemorrhage	1	
Emphysema	1	
Arterio Sclerosis	3	2
Morphinomaniac	1	1
Malaria	3	2
Tuberculosis	2	1
Chr. Alcoholism	2	2
Delirium Tremens	1	1
Pertussis	4	
Childbirth (Septicemia)	1	1
Small Pox	1	1
Syphllis	1	
Blood clot in heart	1	1
Mitral Murmur Art. Scl.	1	
Asthma	1	
Poison accidentally	1	1

Cases with complication, 57; cases with complications terminating in death 21; cases with complications terminating in crisis, 15; cases with complications terminating in lysis, 1

Bacteriological examinations show that over 80% of cases which terminate by lysis have a double infection, either pneumonia with Pfeiffer's bacillus or with malaria or with Bac. tuberculosis, or some other intercurrent condition.

conditions. We cannot always have trained nurses to carry out these instructions, and you cannot get people to do it, and I know that many people would not give a cold bath or a cold pack. If the Doctor did it, he would not make a second call. Of course we all give calomel the first thing we do. We frequently give castor oil. There is one point in the treatment that has been condemned that I use a great deal. We get a case of pneumonia that has a temperature of, say 103, that is suffering, and we have to do something to relieve the patient or he will die. We have only one resort, and that is to the coal tar products. We have to do it. If you give antefebrin or some of the others, you will make the patient comfortable, control the temperature, and save your patient's life. I have no objection to it. In the general practice among the poor people we are compelled to do it. Frequently opium, of course, is condemned, but occasionally you have to give opium. I generally prefer to give cochineal. I give it for the systemic effect, and I give my medicine until I produce an effect. Do not give any more opium than is absolutely essential. In the use of digitalis you are frequently disappointed.

Dr. J. F. Buquoi.—I do not know that the Doctor brought out anything about the local treatment. I have had good results from listol.

As to the local treatment of pneumonia I know of nothing better than "mustard sinapisms" (*mustard paste*) for children. In sthenic adult subjects the time-honored "fly blister" does good work in the congestive stage. With the new and popular counter-irritant, "antiphlogistine," I have had no experience.

Dr. LeBeuf (in closing.)—I will merely confess that I skipped

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TREATMENT.

In only four deaths the patient was under an antipyretic.

Antipyretics were used in	53	cases
Strychine was used in over	140	"
Calomel in	all	"
Quinine in	120	"
Iodide of Potash in over	10	"
Creosote and Creosotal by mouth	33	"
Creosote by vaporation	2	"
Veratrum Viride	5	"
Aconitine or Aconite	5	"
Atropine (hypodermatically)	13	"
Gelsemium	10	"
Carb. and Chlor. Ammonia in over	100	"
Caffein Cit.	40	"
Sod. Salicylate	23	"
Ice bag to lung affected	2	"
Oxygen	8	"
Digitalis in over	100	"

over three or four pages of my paper which cover the very subjects that the Doctor speaks of especially.

I did not say that I did away with cold entirely. I do not apply it to the lungs. I do use cold when that is necessary. I am sorry that I did not read that portion of the paper. I want the Society to know that I do use cold, and that I merely skipped that portion of my paper.

I thank the Doctor for his criticism.

Society Proceedings.

Orleans Parish Medical Society.

President, DR. L. G. LEBEUF. *Secretary*, DR. ALLAN EUSTIS.
141 Elk Place, New Orleans.

In charge of the Publication Committee, DR. ALLAN EUSTIS, Chairman
DRS. JULES LAZARD and H. DUPUY.

DR. A. C. EUSTIS read a paper entitled

"The Urine in Gastrointestinal Fermentation."

In considering this subject it is not my purpose to discuss the relative increase or decrease of each constituent of the urine, but to limit myself to a consideration of Indican, which to my mind is the most characteristic and important constituent of the urine in all intestinal toxæmias, whether primary or secondary to gastric disturbances.

Indol, the antecedent of indican, has been shown by Kuhne, Salkowski, Ward and others, to be formed whenever proteid undergoes putrefaction, as well as being formed in small amounts in the normal pancreatic digestion. Indol thus formed in the intestinal canal, if absorbed, is oxidized to indoxyl, which in turn, is linked to the sulphuric acid radical, to form indoxyl potassium sulphate, or indican. The changes are well represented by the following equations:

$$\underset{\text{Indol}}{2C_8H_7N}+O_2=\underset{\text{Indoxyl;}}{C_8H_7NO};\ \underset{\text{Indoxyl}}{2C_8H_7NO}+2SO_3+K_2O=$$

$$\underset{\text{Indican.}}{2C_8H_6NKSO_4H+{}_2O}$$

These changes are brought about by the cells of the liver, and this synthesis is an example of nature's ability to form a less toxic substance from a very toxic one. As shown by Nencki in 1876, however, the liver has the power of detoxicating only a certain amount of indol. He introduced a solution of indol into the femoral vein of a dog, allowing one cubic centimeter to flow in every five minutes, and examined the blood obtained from the femoral artery of the opposite side from time to time. He found that if one gram of indol was introduced in the twenty-four hours that there were no toxic symptoms, and he was unable to detect any indol in the blood obtained. However, if two grams were introduced in twenty-four hours, the animal developed severe toxic symptoms, indol was obtained in the distillate from the blood, and large amounts of indican could be detected in the urine. These experiments show that if an excessive amount of indol is absorbed from the alimentary canal, or if the liver is diseased and is unable to detoxicate the indol, a train of symptoms will appear, characteristic of this poison. Numerous experiments have been conducted to determine the toxic effect of indol by such men as Rennie, Calvé, Christiani, Ravighi and by Herter in this country. Ravighi, in 1898, experimented upon rabbits and found that the fatal dose for this animal was from one and a half to two grams, the animals dying with symptoms of widespread paresis, feeble heart action, great lowering of body temperature and retention of urine and feces. Herter experimented upon seven dogs and also upon four medical students. His experiments upon the seven dogs showed that the introduction of fatal does of indol into these animals, whether intravenously or by mouth, caused symptoms of cardiac and respiratory failure, great depression, general prostration, marked contraction of the pupils, increased reflex excitability and irregular clonic spasms with subsequent death.

Even small quantities of indol, administered subcutaneously daily, he showed, are capable of initiating profound disturbances of nutrition which end in death in the course of a few weeks, characterized by progressive loss of weight without commensurate loss of appetite, listlessness and prostration. His experiments upon the human subject are of especial interest, as he was able to reproduce experimentally the same symptoms so often met in cases of excessive indicanuria. If small doses were taken by the mouth (0.1-0.3gm) and repeated for a few days, the men were uniformly seized with a dull feeling in the head, usually frontal, which, if the daily dose was continued, because a severe headache. There was a feeling of languor and inability to work, with lack of memory, irregular pains over the entire body, nausea, and restlessness during sleep, the sleep being disturbed by fantastic and lucid dreams. The subjects were nervous and he mentions that the patellar reflexes were increased. If a large dose is taken (one gram) for two or more days, severe colic, with diarrhea, ensues, with great prostration. He found also that the different individuals tolerated the ingestion of this substance to a varying degree, which, to my mind, means that their livers differed in their respective abilities to perform the synthesis noted above. It was noted in these experiments also that the urine examined before the indol was taken contained no indican, while after ingestion of the indol there was always a great excess of indican in the urine.

Regarding the several tests for indican in the urine, there is only one which is sufficiently simple for the average practitioner, viz., Jaffé's test. To conduct this test we proceed as follows: Five to ten cubic centimeters of the urine are mixed in a test tube with an equal volume of concentrated hydrochloric acid, and to the mixture two drops of a saturated solution of chlorinated lime are added, and one cubic centimeter of chloroform. The contents of the test tube are well shaken and finally allowed to stand for ten minutes, with occasional agitation. If indican is present in the urine in appreciable amounts the chloroform which settles to the bottom of the test tube in a distant layer is colored a deep blue or a light blue, depending upon the content of indican. The indican in the urine is oxidized to indigo, which is soluble in the chloroform, imparting its color to the latter liqud. Care must be taken that too much chlorinated lime is not added, as with an excess of this reagent I have seen urines rich in indican give a negative reaction, depending upon the fact that the indigo blue has been oxidized to indigo white. If uniform procedures are carried out with this test, it is very easy to distinguish a diminution or increase in the amount of indican. To my mind, notwithstanding some of the text-books upon the subject, whenever the chloroform is colored blue we are dealing with a pathological urine. It is needless to state that the daily amount of urine excreted in 24 hours should always be taken into account.

For the quantitative estimation of indican in the urine the best method is that of Wang, but this test as well as those of Obermeyer, Strauss and others, are too tedious for the busy practitioner and I will not burden you, therefore, with their technic.

The clinical aspect of indicanuria now confronts us, and I know that there are some here tonight who think it has little or no clinical value. You will, therefore, bear with me if I mention some of the results of other workers along this line besides myself.

Herter, in thirty-two cases presenting so-called neuresthenic symptoms, found an excess of indican in the urine of twenty-one. Wesner went further, and made quantitative estimations of the amount of indicanuria in even a greater number of such cases, and some of his cases are of such interest that I deem a short resume of a few is permissible.

Case 1. Was a patient living on a meat diet in whom there was headache, irregular pains in the limbs, notwithstanding that the bowels were apparently normal. He found a total excretion of 20 milligrams of indican. This same patient, after appropriate treatment aimed at the reduction of this substance, improved greatly after the daily excretion had been reduced to six milligrams. He does not state what was the ultimate result of this case.

Case 10. a nervous, irritable patient, with frequent attacks of vertigo, presented a total excretion for the 24 hours of 2 milligrams of indican and with the disappearance of the indican there was a disappearance of the symptoms.

He found that patients with more than three milligrams of indicanuria presented these same symptoms. Deland read a paper before the Pennsylvania State Medical Society in 1904, and calls attention to the fact that it is important to examine the urine for indican in cases of typhoid fever, and where indicanuria occurs an intestinal antiseptic is indicated. Churtin further reports a case of supposed typhoid fever which was found to be simple acute intestinal toxæmia, and which quickly recovered after thorough purgation and an abstinence from proteid food. His treatment was based entirely upon the excessive indicanuria present. (I will state that I have had a similar case in my ward at the Charity Hospital during the past two weeks.)

C. E. Simon, of Baltimore, collected 114 cases of anhydrochloridia from various causes, 16 of his own and the others from literature, and he found that in carcinoma of the stomach 76.93% presented increased indicanuria, in hysterical anhydrochloridia 66.66% presented increased indicanuria, and in acute gastroenteritis 100% presented this condition.

This is easily accounted for by bearing in mind that secondary intestinal fermentation follows gastric fermentation. The gastric juice being deficient in hydrochloric acid inhibits the digestion of proteids not only in the stomach, but, as shown by Pawlow, in the intestinal canal as well, from nonstimulation of this latter secretion. Undigested proteids decompose.

I could mention many other incidents in which this test is of value, but I will content myself with a short resume of some of the cases in which it has been of inestimable value to me.

Case 1. Mrs. G., a married woman thirty-five years of age, had been treated for "neurasthenia" for a number of years, and had been accustomed to take large doses of the coal tar products for severe headache, which was almost constant. She was a highly sensitive patient, and while of a naturally amiable disposition, she had become of recent years a nervous, irritable patient, with great tendency toward hysteria. I have been called to see her in several attacks of pure hysteria, brought on by excessive headache. Examination of the eyes by a competent specialist showed them to be absolutely normal. All viscera normal and age showed no pathological condition, excepting slightly increased patellar reflexes and a marked indicanuria, which was almost constant, until proper treatment was instituted. Bowels moved regularly, apparently, once a day, but that there was some intestinal toxæmia was shown by the marked indicanuria. She was put upon nightly doses of cascara, aloin and podophylin, with phosphate of soda three times a day. The indicanuria gradually subsided and along with the disappearance of this substance from the urine, the disposition returned to its former normal condition, the headaches vanished and now she is apparently a woman in perfect health.

Case 2. Mr. D., aged 32, white male, a clerk by occupation, was seen by me October 11, 1904, with a temperature of 108.8° F., pulse 100, respiration 16. He was complaining of severe pain in the right thoracic region, increased on expiration, with severe headache. The visceræ were all normal, with the exception of the liver, which was painful to pressure, measured 8 inches in the memary line, 9¼ in the axillary line and 9½ in the scapular line. His bowels had been moving regularly once a day, and the attack was of sudden onset, being ushered in by a chilly sensation. Blood count showed 10,500 white blood cells, no plasmodium malaria, but the urine showed large amounts of indican by the Jaffé test. Treatment was directed to intestinal purgation and hepatic stimulation, with the withdrawal from the diet of all nitrogenous foods, with the result that in two days the liver had diminished to its normal size and all symptoms had disappeared.

Case 3. Colored woman, 23 years of age, was admitted to my ward at the Hospital, with temperature 104° F., in a more or less stupor, dry, furred tongue, distended abdomen and all the other clinical symptoms of typhoid fever. Widal's reaction was negative and a routine examination of the urine for indican showed this substance greatly in excess. Purgation and intestinal antiseptics was at once instituted, with complete recovery in two days.

Case 4. A patient of Dr. Metz came under my observation only in the examination of the urine. I am indebted to Dr. Metz for the following facts: The patient, a wealthy merchant of this city, had come to him complaining of inability to perform his work, with occasional headaches and feeling on the verge of a general breakdown for some weeks past. He contemplated a trip abroad to one of the watering places, thinking that perhaps he was over-worked. On examination of the urine we found such a great increase in the amount of indican that Dr. Metz directed treatment towards this condition, with complete recovery and absence from all disagreeable symptoms and, I might add, with a change in the decision of the patient to visit Europe.

Case 5. A young married woman came under my observation during her first pregnancy. There were no untoward symptoms during the progress of pregnancy, excepting occasional morning nausea and vomiting. When I first saw her in one of these attacks of vomiting, I found large amounts of indican in the urine.

Thereafter she was placed upon mild laxatives at night and had but two subsequent attacks of vomiting during the pregnancy, and in each of these instances the urine was loaded with indican. I was able to control the condition of the intestines by repeated examinations of the urine for indican, and as the indican increased in amount, it would invariably be associated with a tendency to nausea.

I could mention other cases, but my wish is only to bring before the Society due recognition of the importance of indicanuria.

In concluding, I would state that where we encounter patients with chronic headache, feelings of lassitude or hysterical symptoms, it would be well to examine the urine for indican before prescribing bromide or the coal tar products. Where an excess of indican is found all proteid matter should be eliminated from the diet until the condition is overcome, divided doses of calomel, phosphate of soda, cascara or other cathartics should be given. I believe also that this is one condition in which intestinal antiseptics are indicated, to inhibit the growth of the colon bacillus, the principal producer of indol.

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DISCUSSION.

DR. WEIS stated that the intimate relationship between indicanuria and disorders of the liver is shown by the fact that whenever urophane is diminished in the urine, there is always a corresponding increase in the indican. His method for the detection of indicanuria is to add 20 drops of concentrated hydrochloric acid to the urine in a conical glass, allowing it to drop from a pipette held about six inches above the fluid; after stirring the mixture and allowing it to stand, an amethyst color appears, which is pale to yellowish if indoxyl is diminished, and deep amethyst or purple if increased. The reaction may be hastened by addition of one drop of concentrated nitric acid.

DR. SIMON stated that he was not prepared to accept the fact that indicanuria had the broad clinical significance that Dr. Eustis claimed for it. The subject had been discussed widely for many years, but he was unable to find any reliable authority who attached so large a clinical significance to it. Nothnagel claims that the state of obstruction of the bowels as between the large and the small guts, can be ascertained by examination of the urine for indican; an excess of indican pointing to obstruction in the small gut, since indol, the antecedent of indican, is formed only in the small intestine and not in the large. Further, in diseases of the pancreas, accompanied by an occlusion of the duct, there is always an absence of indicanuria, and this may be taken as an important aid in the differential diagnosis of some knotty abdominal problems.

A serious factor in the causation of increased amounts of indican in the urine is the presence in the body of a large amount of imprisoned pus, such as in empyema.

As far as the presence of indicanuria in the circulation, acting as an autotoxic agent and giving rise to neurasthenic symptoms, he did not consider this proved, as an indicaburia may be found normally in many persons who do not exhibit any toxic symptoms.

It must be remembered that indican is a normal element of every urine and about 10 mgr. are excreted daily. He, therefore, was not prepared to accept the fact that indicanuria in itself was a cause of autotoxic symptoms any more than a phosphaturia or an acetonuria, under like conditions, would be.

Dr. Eustis, in closing the discussion, stated that he did not lay great claims for the clinical value of indicanuria. but that he did think, and this opinion was based upon actual clinic facts, that indicanuria does denote a toxic condition, the toxic symptoms being manifested variously in different individuals. He knew that the text-books claimed that there was no clinical significance and this was the reason for his presenting his paper to the Society, as he considered that there were certain cases which are often treated with coal tar drugs to relieve headache or sent to a nervous specialist, which could be cured by simple purgation and proper diet. Regarding Nothnagel's claim, brought out by Dr. Simon, that indol is formed only in the small intestine, it is absurd to think that this is possible when we realize that the colon bacillus, the most active producer of indol, resides especially in the large intestine. Further, indol and skatol are distinct products of the large bowel and give the characteristic odor to the human feces. Wherever albuminous matter undergoes decomposition, and especially, as shown by Ward and others, in the presence of the colon bacillus, large amounts of indol are formed. Indol, if formed in the large intestine, will be absorbed as well as in the small intestine. The other clinical value of indicanuria, quoted by Dr. Simon, that is, in the diagnosis of diseases of the pancreas, it has been shown by Porru-Costa and others that there is no relation between diseases of the pancreas and indicanuria. These two instances cited by Dr. Simon as a matter of fact were instances in which the test is of no value. Regarding the presence of indicanuria where a large collection of pus exists, it was to be understood that such should be looked for, but that when free purgation fails to eliminate indican from the urine, the excessive indicanuria even strengthens this diagnosis along with a blood count, etc.

Dr. Eustis admitted that there were many patients presenting excessive indicanuria without any apparent symptoms, and that it was to be expected that the organism may become immune to the toxic action of this substance just as to morphin, caffein or any other toxic substance, but after analyzing the symptoms produced by experimental ingestion of indol in chronic doses, it will be seen that Dr. Simon is exaggerating when he claims that it is non-toxic. The speaker could not understand how any one without any personal experience could state that indol is not toxic, when such a man as Herter points out, after actual experimental research, that it has distinct toxic effects. Regarding the test outlined by Dr. Weis, he had used it, but considered that it necessitated a greater excess of indican to obtain a positive result than with Jaffé's test. And further, when patients have been taking the iodides a brown ring at the junction of the two liquids will obscure the indigo ring.

DR. SIMON, speaking again, in reply to Dr. Eustis, stated that in order for indol to be formed, the albumin of the food must first be transformed to albumoses and peptones, which is done by the digestive juices, most especially the pancreatic juice. It is from the bacterial decomposition of these products of proteid digestion that indol arises. The part that the pancreatic juice plays in its formation is thus evident. It is in the small intestine, then, that indol is formed and not in the large intestine, from which the albumin and peptones are absent, having already been absorbed. The experiments of Dr. Eustis mentions with indol might hold for this substance, but it is not indol which circulates in the blood, but indoxyl potassium sulphate or indican. Immediately after being absorbed from the small gut, the indol attaches to itself a K_2 SO_4 group from the blood and becomes indican, in which form it is excreted by the kidneys.

DR. EUSTIS, in finally closing the discussion, stated that Dr. Simon was wrong in his assertion that in order to obtain indol the albumin must necessarily be changed to albumoses by the pancreatic juice. True albumoses are an intermediate product between the two, but they are formed by the colon group of bacilli in the production of indol. The speaker stated that he was not speaking from theoretical grounds, but from actual practical experience. He had made indol from albumin simply by allowing it to putrify, and the usual method for the production of indol for experimental purposes is to allow blood fibrin, which certainly contains no albumoses primarily, to decompose. True, indol and indican are two distinct substances, but in his paper the Doctor had spoken of the detoxicating action of the liver cells, and where clinical symptoms are manifested it shows that either too great an excess of indol is formed to be synthesized into indican, or the liver, which produces this synthesis, is unable to function, and the toxic symptoms are therefore due to indol and not indican. Indicanuria was certainly an index of the amount of indol in the circulating blood, other things being equal. He wished to urge the members to make a routine examination of the urine for indican, as he really felt it would aid them in clearing up many obscure cases.

Dr. F. W. Parham read a paper entitled

"Hemorrhage Into the Cecum from an Anomalous Appendicular Artery."

M. G., aged 25, was admitted to New Orleans Sanitarium July 9, 1904. He had had about one month previously a severe attack of appendicitis, during which I saw him once. He suffered acutely with the usual symptoms of a typical attack, but there was otherwise nothing noteworthy. He determined not to run the risk of another attack, and asked me to remove his appendix. With the concurrence of his attending physician, Dr. J. T. Scott, I agreed to do so after he had completely recovered. So, on July 12, after three days' preparation, I did the operation through the McBurney gridiron incision, beginning about 9 a. m., the anesthetic being chloroform.

The appendix was found without great difficulty, but there was some trouble, owing to rather firm adhesions, in delivering it through the small opening in the muscular wall. However, there was nothing striking about this, since we often meet with just such conditions in cases that pursue absolutely normal course of healing.

I shall dwell, in the description of the technic, only upon the method of removal of the appendix and the closure of the opening in the cæcum. The method was that of Dawbarn. The appendix was clamped between forceps and cut off close to the proximal clamp by a scalpel. The clamp was then removed, the stump tucked well into the lumen of the cæcum and a purse-string suture, previously introduced around the base of the appendix, drawn up and tied. Four fine silk sutures in milliners' needles were then in Lembert fashion, and, being tied, covered the opening beautifully with peritoneum. The cæcum was then pushed into the cavity and the wound closed in the usual way. Those of you who do appendicectomies frequently would say that this McBurney-Dawbarn method is ideal, and so it is, in the great majority of cases, but listen to the sequel and you may be more disposed to heed the injunction of St. Paul: "Let him that standeth take heed lest he fall!"

The young man was carried from the table to his room in excellent condition and put to bed.

July 13, 11 A. M.—(24 hours after leaving operating table): Doing well, but complaining of some abdominal discomfort from gaseous distension. Ordered colonic enema of soap and water. This was expelled in twenty minutes with clotted blood.

5 P. M.—Enema repeated with same result.

7:30 P. M.—Passed a quantity of clotted blood.

10:30 P. M.—Another stool of blood-clots.

12 P. M.—The fifth stool of blood-clots.

He continued to pass large quantities of clotted blood up to 4 a. m., when I reached him, having been summoned by telephone. I saw some of the large stools which had been saved for me. Questioning the nurse, I became satisfied that he had really lost an immense amount of blood, and this belief became a certainty when I examined the young man. He was very pale and quite weak and depressed, with pulse 130. Dr. McGuire, the resident physician, who had been with him for a good while, assured me his pulse had become steadily more frequent for several hours, and especially for the past hour. I acted at once, doing intravenous infusion of about two pints, 115 degrees to 120 degrees, at 4:30 a. m. P. D. & Co.'s. ergone M. XV, strychnin sulphate gr. 1-30 and morphin sulph.

1-8 were given subcutaneously at once, and the morphin repeated quickly to stop intestinal peristalsis. Strychnin, ergone with adrenalin m. x. were continued every three or four hours for several days.

July 18, six days after operation, gas was expelled with dark blood, the first since the intravenous infusion.

July 19, one week after the operation, the first purgative was ordered, of sulphate of sodium every hour from 10:30 a. m. After three doses there was large result, old blood-clots and fecal matter, but no fresh blood. At 8 p. m., large similar stool.

July 20, the diet, which had been chiefly liquid, was now changed to light diet.

The ergone alone was continued until July 22, when all medicines were discontinued.

He was discharged July 29, seventeen days after the operation, his prolonged stay being due not only to his weak condition, but partly also to subcutaneous suppuration in the wound, which had to be opened superficially and subsequently resutured. He left in good condition, some degree of pallor, however, still remaining. He tok a sea trip later to New York, returned after a few weeks renewed in health and now shows no ill effects of the great loss of blood.

REMARKS.

The case is interesting for two reasons:

1ST. On account of its causation.

2D. On account of the effectiveness of the measures adopted.

I shall dwell only upon the first point, the source of the hemorrhage.

It might be thought to be due to the traumatism of the cæcum in drawing it through the constricted muscular opening. I thought myself, at first, this might be the explanation. Bleeding piles might have explained it, but there was no evidence of any or of anything else within reach that could explain the bleeding.

I was much tempted to open the wound, but reflection convinced me, that as the hemorrhage was confined *to the lumen* of the intestine, the abdomen geting *flat* and giving no evidence on palpation of any *intraperitoneal* hemorrhage, I concluded to await the effect of the homostatic measures. Fortunately, no further alarm was given.

I was at a loss to conceive any adequate explanation until I received a reprint of Seelig's interesting and valuable paper published in the *St. Louis Medical and Surgical Journal* a few months after this case. I think he shows conclusively that hemorrhage *may* occur from the appendicular artery into the cecum under certain circumstances when the purse-string method with invagination of the stump is done, and I am satisfied that this occurred in the case reported.

The anatomical explanation is very clear: Whilst in the vast majority of cases the appendicular artery, a branch of the post-cæccal branch of the ileo-colic branch of the superior mesenteric artery, passes in the free border of the meso-appendix to the tip, in a small percentage of cases it runs *in the wall* of the appendix. In this case it is readily seen that the simple inversion of the appendix stump into the cæcum and the tying of a purse-string suture about the base would not constrict this vessel, and it might go on bleeding into the lumen until the occurrence of bleeding first became evident in the passing of blood by stool. It is also clear, that even the opening of the peritoneal cavity and the exposure of the closed appendix opening might not lead to the discovery of the source of the hemorrhage.

If one could recognize these anomalous cases at operation, of course, the safest thing to do would be to follow the suggestion of Seelig, Lilienthal and others to put a ligature around the appendix. This would be effectual. But most surgeons are at present unwilling to discard the ingenious and admirable purse-string method of closure, which has some decided advantages over the ligature method, which has only two to recommend it, very strong ones I admit, namely, quickness of execution and certainty of preventing the rare complication of the operation reported in this case.

DISCUSSION.

DR. BAYON, in opening the discussion, stated that he had had occasion to examine the appendices of twelve cadavers since Dr. Parham had spoken to him of his case, but that he had not found a case in which the artery ran in the walls of the appendix, nor had he been able to find any mention of such an instance in literature. He had observed an instance where the appendicular artery supplied only the distal end of the organ, the proximal end being supplied by the posterior ileo-cæcal artery, which by its anastomosis with the appendicular artery, would explain hemorrhage in the cæcum, after appendicectomy, if the appendix itself was not ligated. He then spoke of the possible dangers to be met after ligature of the appendical artery too high or too low, illustrating same by diagrams.

Dr. E. D. Martin said that Dr. Mayo, of Rochester, Minn., whom he had seen operate last summer, follows the practice of throwing a loop around the artery in passing his purse-string sutures. Dr. Craig, of Boston, had told him that he had given up inversion of the stump, and now followed the practice of simply crushing and ligating the stump. Not long ago, Dr. Martin, in performing an appendectomy, had made a peritoneal cuff at the base of the appendix and ligated the stump and had then covered the stump by suturing the peritoneal cuff over it. He had an excellent result in this case, but in a subsequent case the result was bad. However, he considered it a rational procedure and intended to give it further trial.

Dr. Walet said that in his next case of appendectomy, he would be tempted to run a continual suture around the stump, and if such an anomalous artery existed, as in Dr. Parham's case, it would be included in the ligature.

Dr. Fenner was very much interested in the paper of Dr. Parham and considered it a timely warning; however, it was impossible to theorize as to the probable cause of the hemorrhage in this case. He approved of Dr. Walet's idea of running a continuous suture around the stump.

Dr. Parham, in closing the discussion, thought that the hypothesis of Seelig in these cases does not coincide with his case, especially after the diagram of Dr. Bayon. Mayo's method, mentioned by Dr. Martin, ought to overcome any danger from post-operative hemorrhage. Dr. Kelly found in 16% of cadavers that the mesentery of the appendix extends only half way and he advanced the theory that the artery from here on passes inside of the appendix.

RELATION OF CASES AND MEDICAL NEWS.

DR. FENNER reported *a case of epispadias* which he had operated upon three years ago by Cantwell's method. An opening was left after the operation in the dorsum of the penis, which would permit of the introduction of only the finest wire, but from which urine dribbled on standing. Two days ago he operated upon this fistula. It appeared that the urethra had dilated beneath this fistula, forming a pouch, from which the urine dribbled when the patient was in the erect position. Patient had full control of the bladder and there wsa no dribbling when he was lying down.

DISCUSSION.

DR. MARTIN stated that Dr. Parham and he had recently operated upon a case of epispadias, which presented the same condition as DR. FENNER's case, namely, control of the bladder in the supine position, but dribbling in the erect position. The patient had only a glans penis, the odrsum of the body being entirely absent. At the first operation it was necessary to borrow skin from the pubes to form a body and the last operation was simply to narrow the new urethral channel. This was done by dissecting the pouch and cutting off the redundant tissue.

DR. FENNER said that there seemed to be a deficiency of tissue and he wished to know whether any of the members had had any experience with the injection of paraffin in this region, as he thought it could possibly help some.

DR. PARHAM stated that every case operated upon this condition presented more or less incontinence of urine, and he remembered that paraffin was at one time advised, but that he had had no personal experience with it.

DR. HUME stated that paraffin injections have been used very extensively for incontinence of urine, especially in women. He had seen one case of incontinence of urine following a Bottini operation for enlarged prostate, in which injections of paraffin were used, but with no effect. He had seen a case of hypospadias operated upon last summer by Dr. Stafford, in whihc there was retention of urine. He had been consulted by Dr. Stafford, and had advised supra-pubic aspiration of the bladder. which was done eleven times, with complete recovery, and without the usual practice of performing a perineal section. He considered this procedure an excellent one, when performed under aseptic conditions, and was surprised that it was not practiced oftener in this section of the country.

Avoyelles Parish Medical Society.

Plaucheville, June 19, 1905.

Meeting called to order by the Chair, Dr. C. J. Ducoté. The Secretary, Dr. E. S. Matthews, being absent, the reading of the minutes of the Cottonport meeting was dispensed with. The Chair appointed Dr. Drouin temporary secretary. Members present: Dr. C. J. Ducoté, W. F. Couvillion, T. E. De Nux, T. Barbin, W. A. Quirk, S. A. Couvillion, P. Jeansonne, E. Kiblinger, J. J. Haydil, T. A. Roy, E. Regard, G. A. Drouin, G. R. Fox, J. Boyer, J. D. Lemoine, B. J. Lemoine, H. Lemoine and A. L. Bordelon.

A paper entitled "Puerperal Septicemia" was read by Dr. G. R. Fox. After the reading of this paper Dr. C. J. Ducoté offered a vote of thanks to Dr. G. R. Fox for having presented the Society with such an elaborate and instructive paper.

The discussion was opened by Dr. S. A. Couvillion and followed by Drs. Kiblinger, Roy, Regard, W. F. Couvillion and Fox.

The resolution passed at the last meeting regarding midwives was discussed, and the following resolution was introduced by Dr. G. R. Fox:

Be it Resolved, by the Avoyelles Parish Medical Society, that we urgently request the Louisiana State Medical Society, through its Committee on Legislation, to introduce a bill at the next meeting of the State Legislature, amending the Medical Practice Act, regulating the practice of midwifery in this State, so that all midwives shall be required to be licensed by the State Board of Medical Examiners.

Be it Further Resolved, That the President of the Avoyelles Parish Medical Society be authorized to utilize any unexpended funds of the treasury of this Society to test the legality of Act 49, Section 5 of 1894, which is the present law governing the practice of midwives in rural districts.

By Dr. E. Regard:

Resolved: That the members of the Avoyelles Parish Medical Society feel themselves honored in the election of one of their members to the Presidency of the Louisiana State Medical Society.

Resolved Further: That we extend to Dr. Ducoté our personal congratulations;

Resolved Further: That it should be the patriotic duty of the members of the Parish Medical Society to attend *en masse* the next meeting of the State Medical Society.

Afternoon Session.

At 2 p. m. the Chair again called the meeting to order, and there being no other scientific subject offered for discussion, the following resolutions were acted upon:

By Dr. F. W. Couvillion:

Resolved: That a Committee be appointed by the President of the Avoyelles Parish Medical Society, to go before the Police Jury at their next session, and urge upon them the necessity of improving the public roads.

Thereupon the President appointed the following: Drs. Couvillion, Roy and Fox.

By Dr. G. R. Fox:

Be it Resolved: That all communications to the Secretary, made by members of this Society concerning midwives, be held strictly confidential.

By Dr. T. A. Roy:

Resolved: That it is the sense of this Society that during the absence of one of its members that all cases of lying-in-bed that he has been daily attending to, if treated by another member during said absence, that the fee resulting from this service is to be turned over to the said absent member on his return.

The selection of the next place of meeting was then discussed, and upon the invitation of Drs. Fox and Boyer, Moreauville was designated the next meeting place, the first Thursday in October.

Subject for discussion at next meeting: "Specific Urethritis, Acute and Chronic, With Its Complications."

Dr. Kiblinger was appointed to write a paper upon this subject, and Dr. S. A. Couvillion to open the discussion.

Meeting adjourned.

E. S. Matthews, M. D., *Secretary.*

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

The Portland Meeting.

The fifty-sixth annual meeting of the American Medical Association has come and gone. It was held at Portland, Oregon, on July 11 to 14, and attained quite a measure of success. The attendance reached nearly 1,800, which was excellent for a place so remote from the centers of population.

The local profession and the people did all in their power to make things enjoyable for their guests, and everybody, notwithstanding a few hardships endured, had a good time. This phase of the proposition can best be described in a nut-shell, especially in reference to the feelings of the Portland doctors, but also to those of the strangers, by repeating the story of the girl who had just taken her first toboggan ride in Canada. She said it was the finest thing she had ever experienced in all her life, but she wouldn't try it over again for anything in the world.

The truth of the matter is, that the Portland contingent worked like trojans and the others enjoyed themselves, but the Rose City is too new and not quite large enough to handle without great effort, a meeting of the A. M. A.

Portland is well-named the Rose City, for the queen of flowers, as tree or bush or vine, abounds everywhere, is delightfully perfumed, and attains enormous size. The city is well laid out, is clean, has good street car service and possesses an enchanting climate. The registering thermometer on the hotel piazza recorded nothing less than 50 deg. nor more than 70 deg. during the week of the meeting, and only once these extremes, hovering most of the time in the neighborhood of 60. In the coldest winters the temperature rarely gets as low as 10 deg. above zero.

The House of Delegates was numerously represented, and its meetings well attended. Of the large number of amendments proposed to the By-Laws, but few were adopted. The only two of importance were one providing for oral nomination of the officers except the treasurer, who is still to be nominated by the trustees, thus doing away with the nominating committee; the other puts the control of all arrangements for the annual sessions under the control of the Board of Trustees, who may appoint a local committee which shall remain under the control of the Board.

The report of the Trustees showed that the Association is in a flourishing financial condition, with assets of $213,470.

The expected discussion about what was to be considered ethical for doctors to use and journals to advertise, and which promised to be quite warm, was successfully (?) disposed of by the report of the special committee which seriously enunciated the *dictum* that NOSTRUMS and their use should be frowned down and should not be advertised in proper medical journals. That is surely elastic enough for most purposes, and one might well add, "you pays your money and you takes your choice."

The only exciting event was the discussion upon the proposition to publish a directory of *all the licensed practitioners* of the United States and the purchase as a means towards this end of the Standard or Engelhardt's Directory. Some did not favor the publication of a general directory, but wanted it limited to the members of the Association; others thought it would be boycotting the poor fellows who were not yet members, but would be induced to become such if they were not left out and only tagged as non-members. Some did not favor the purchase of an inaccurate directory; others thought it a *sine qua non*, as otherwise the Association would have to spend all its money to make up its own directory. It ended by the Trustees having their own sweet will and being authorized to publish a directory of all legal practitioners, and to buy Engelhardt's Directory for a sum which they (the Trustees) did not feel authorized to divulge.

The House elected the following officers: president, Wm. Mayo, of Rochester; first vice president, Walter Wyman, of P. H. and M. H. Service; second vice president, K. A. J. Mackenzie, of Portland; third vice president, Eug. Talbot, of Chicago; fourth vice president, E. D. Martin, of New Orleans; (we came away with something, anyway); secretary, Geo. H. Simmons, of Chicago; treasurer, Frank Billings, of Chicago. The three vacancies on the Board of Trustees, after numerous nominations and an exciting race, were filled by the re-election of the three outgoing incumbents: Montgomery, of Pennsylvania; Johnson, of District of Columbia, and Wright, of Iowa.

As orators on medicine, surgery and state medicine, respectively, were elected F. C. Shattuck, of Boston, Jos. D. Bryant of New York, and W. H. Sanders of Alabama.

Boston was selected as the place of meeting in 1906.

The section work was creditable; many good papers were read and the discussions were interesting, but nothing startling was developed. The allied associations held their usual annual sessions and had successful meetings. The principal ones were: the American Urological Association; the American Medical Editors' Association; the Society for the Study and Cure of Inebriety; and the Association of State Medical Journals.

The entertainments were numerous and largely attended, sometimes too largely for comfort, but that was a natural consequence and everybody made the best of it and all enjoyed themselves more or less. Both Tuesday and Wednesday morning there was a ride to Portland Heights, on the trolley, and a magnificent view of the city and vicinity was obtained. Tuesday evening a reception was given at the American Inn (The Inside Inn of the Exposition); this was followed by a special performance of Kiralfy's Carnival of Venice, giving unlimited opportunities for pantomime, ballets, and music. Wednesday evening receptions were tendered by Mrs. R. B. Wilson, Mrs. K. A. J. Mackenzie, and Mrs. Wm. Jones, at their residences, and by Dr. and Mrs. H. W. Coe at the Oregon Building in the Fair Grounds. At all places, pretty women beautifully gowned and surrounded by choice samples from the Rose City's gardens made lovely pictures which will long be remembered. Thursday evening a reception and musicale was given at the "Oaks," a pleasure resort reached by trolley and corresponding to the "West End" of New Orleans.

Friday morning was the last and most enjoyable of the entertainments. As many of the guests as the four boats chartered for the occasion could hold left at 9 o'clock for an excursion up the

Columbia River. Those who could not be accomodated went by special train at noon to join the others at Bonneville, where an *al fresco* luncheon was served. They were given the first chance at getting back by boat, so that all had the opportunity of making the trip at least one way by water. It was a delightful outing, and we were all able to witness the scenery, which is unsurpassed in its way, many claiming it to be superior in beauty to that along the Hudson.

Of course, the "Trail," which is synonymous with the "Pike" at St. Louis and the "Midway" at Chicago, was pretty well patronized, and no doubt many members will have amusing incidents to relate when they reach home again about "Gay Paree" and the "Streets of Cairo."

The addresses of welcome delivered at the opening general meet- governor of Oregon and the Mayor of Portland were Democrats, ing were unusually good, and brought out the fact that both the elected in a Republican stronghold. Also we were glad to find that the mayor was a practicing physician and good at both lines. He usually is a strict enforcer of the laws, in fact was elected on that platform, but on this occasion had instructed the chief of police to see that no member of the A. M. A. was to be interfered with unless it could not possibly be avoided.

We hope Mayor Lane's orders were not found too hard to follow by Portland's finest, but many of the city's guests, after a shellfish dinner at the "Quelle," where good Munich Beer is also dispensed, seemed to own the town on the Willamette. By the way, the name of this river is no longer pronounced as when the JOURNAL representative went to school. The right way now, and this was told as the way to remember it, is to pronounce it so it will rhyme with "damn it."

By any other pronunciation it would be just as fine, the people that live on its borders just as hospitable, the climate just as heavenly, so that one, at least, does not say like the Canadian girl, for he would be glad to take that toboggan ride again.

The Scope of Health Boards.

Considerable agitation has attached to the political character of the New Orleans Health Board and the office of its president. Fortunately for the community, the Mayor made it the subject of a special message to the Council that the present Board should rest for the coming year. Incidental to the issue, memorials were addressed to the Council from almost every commercial body in the city and from professional men urging the retention of the present Board. This public recognition of the work of Dr. Kohnke has evidently been well deserved. When the State Board of Health was established as a dignified body in 1898, the New Orleans Board of Health was duly divorced from the State supervising authority and it began a career of usefulness under the direction of the present able Health Officer, Dr. Quitman Kohnke, and the Secretary of the Board, no less zealous, Dr. Sidney L. Theard. Starting with an antecedent history of perfunctory health supervision the Board has accomplished quite a number of important results in this community. Meat inspection has been perfected and vital statistics have been placed upon a system of recognized usefulness. Smallpox epidemics have been practically annihilated by precautionary vaccination of all classes and especially school children. This Board improved the sanitary control of infectious diseases and has been active in the investigation and disposition of leper cases found in New Orleans. The public has at all times been served with not only a willing but an anxious energy which has even anticipated the public need. We may be justified in declaring that in no community has the public health officer been more devoted in his efforts to educate his constituents in health matters. This has been evident not only in the reports and circulars of the Board to physicians and laymen both, but at all times the public rostrum has been employed and lectures and addresses of no mean merit have been delivered to the general good.

All Boards of Health are open to the criticism of the people and many deserve the adverse judgment which may fall. We are yet in the infancy of sanitary living and it may be many years before the community life responds to the needs of wholesome regulation. The study of health measures the world over will show that each year a broader intelligence is pervading the public itself—and that a response to educational measures is coming. The perpetual dickering incident to political life should be foreign to health control, and the office of health guardians should always seek the fittest to fill it and it should not be a plum for the tallest and greediest to pick.

Vacation.

With the dog days the spirit of man becomes mercurial and the end of life seems nearer; the glories of ambition fade into empty shadows and the tired soul hungers for the boon of natural rest.

Every now and then the chronicle of the sudden demise of a hard worked medico startles us into the reflection that even the animal who drudges during the long day, when the season comes, finds a pasture to recruit his spent energy for another season's labor. Most medical men make the mistake of speculating upon a day of rest postponed always until that future when plethoric success will permit. But long before the chimera becomes a reality the mirage has vanished, the harness is worn in the wearing and it is "too late" to rest. We are philosophers for our patients, directing them to one or another resort of health—advising the recuperative effects of the mountain or seaside—chiefly the benefits of rest, and we watch for their return and congratulate them on the results. It is after all only the question of the recompense, and nature rewards the wise man and the fool, each according to his deserts. Some day a philanthropist will create an Eldorado for tired doctors, and when it is beautifully complete it will be put up for sale, because the tired doctor will have none of it.

Seriously, we ought to have vacations, we ought to rest our minds and souls and bodies, for our own sakes and for the patients' sakes. The competition after all is not worth the candle burned at both ends, and the retrospect of even a successful medical career is barren if we view it with an eye jaundiced with a weary soul and a body eager and watching for a surcease.

Typhoid Fever at Charity Hospital.

Quite a number of cases of typhoid fever have developed in Charity Hospital, and among these a part of the internes and house staff is included. The Board of Administrators have investigated the source of this epidemic, and have discovered through the Bacteriological Department that the trouble comes through the milk supply. Specimens of milk examined show not only typhoid bacilli, but the organisms of tetanus as well. The contractor supplying milk to the institution has changed the source of this provision, and at present all milk used in the Hospital is boiled before it is consumed.

As the milk producing the infection was derived from the town of Hammond, considerable excitement has ensued. The country producers contend that whatever impurity exists must have arisen after the milk reached the city, through the medium of the city dealer. As a result a thorough inspection of the milk supply from Hammond is being carried out by the City Board of Health.

The whole disturbance emphasizes the importance of pure food inspection, as well as laws for the accomplishment of a reform. In some States rigid rules are enforced regarding all food products, whether of natural or factory origin.

Considerable attention has been paid to the gross examination of milk to prevent adulteration in New Orleans, but with this new development, evidently the outgrowth of carelessness, or worse, in the handling of milk cans, more exact and comprehensive methods of analysis must obtain. We believe that our local Board of Health is equal to the emergency, and that their milk inspection will soon be on a par with their thorough handling of the meat supply.

The Health of the Canal Zone.

It is refreshing as well as gratifying to the medical profession, and particularly to us who have been there, to see the statement that health is to be the prime consideration on the Isthmus before serious work is begun on the Canal. Both the editors of this Journal visited Panama in early January, and were impressed with the vast undertaking which faced the Medical Departments of the United States Government. With the absolutely unsanitary conditions pervading Panama, with all sorts of infectious diseases rampant, then, as before, the task looked almost Herculean. Notwithstanding a natural reticence on the part of those in authority, a murmur could be felt against the restrictions which seemed to be associated with every effort towards a free hand in the management of sanitary measures. Here and there work was being done, but it seemed to move slowly.

Recent reports from the Isthmus, and especially from Panama and Colon, would indicate that diseases were as prevalent now as at any other time. Yellow fever has not yet been overcome, and the less frequent but equally disastrous diseases of beri beri, typhus and the plague, not to emphasize malarial affections, are still making the death rate a high percentage of the Isthmian population.

The authoritative statement from Mr. Shonts, the Chairman of the Commission, that the first work of the Commission would be to put the canal zone in a healthful state and to provide pleasant habitations for those employed, will carry a great deal of confidence in those interested in the field. We learn from the reports issued from time to time by Col. W. C. Gorgas that considerable work has been done in planning the sanitation of the entire zone. When the thorough crusade against the mosquito is well under way, and when pure water and plenty of it is provided, with hospital accommodations and qualified nursing, then there is no reason why Panama, or that part of it under United States rule, should not be a pleasure resort in contradistinction to the pest hole it now is.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In charge of Dr. F. W. Parham, assisted by Dr. F. Larue, New Orleans.

DEPRESSED FRACTURE OF CRANIAL VAULT WITH FISSURE EXTENDING TO BASE OF SKULL; INTERVENTION; RECOVERY—Mr. Lenormant (in *Revue de Chirurgie,* May 10th, 1905,) reported to the Societe de Chirurgie, through Mr. Demoulin, the case of a young man, aet. 35 years, who had been struck violently over the parieto-temporal region by a trolley-rod.

The injured, not losing consciousness, walked home, a distance of about 650 feet.

Headache, nausea and vomiting having supervened during the night, the patient was transferred to the hospital. A large hematoma was found over the contused region, with an apparent depression of bone.

Ecchymosis of the right conjunctiva existed at the external and inferior angle of the eye.

A complete left facial paralysis was noted with inco-ordinate movements of the upper left arm.

Mr. Lenormant, diagnosing fracture of the skull with cerebral compression, operated at once. On dissecting a skin flap, with convexity upward, he found a pulpy temporal muscle with an underlying stellate fracture of the inferior part of the parietal and the squamous portion of the temporal. All bone fragments were removed and through this wide gap the dura appeared covered over with dark clots. A meningeal branch was ligated with catgut. With similar material an inch rent in the dura, through which flowed cerebro-spinal fluid, was closed. The skin flap was then readjusted, a small gauze wick being used for drainage.

Post-operative results excellent; union by first intention; the facial paralysis disappeared completely in 48 hours; patient discharged cured in two weeks.

Mr. Demoulin called the attention of the Society to the absence of cerebral commotion after such a terrific blow, to the existence of complete facial paralysis, usually confined to the lower facial, when of cortical origin.

Doubtful as to infection in such a case he considers it more prudent not to close the dura rent and to drain the supra-dural space with a special wick.

Mr. Broca mentioned having seen an illustrative case of paralysis of the lower facial in a child with a fissure of the left parietal.

There was no wound, no hematoma of the scalp, no depression or displacement of fragments.

The paralysis was secondary, appearing two days after and caused by a cortical hematoma. Mr. Broca trephined, cleared the blood collection, with complete recovery.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER, New Orleans

LUMBAR PUNCTURE IN ECLAMPSIA.—Henkel (*Centralbl f. Gynäk.* No. 45) reports sixteen cases of eclampsia treated by lumbar puncture. The mortality reached 25%, which is no better than the average mortality. No fluid was obtained after puncture in seven cases. In one of the fatal cases no fluid was found in the spinal canal at post-mortem. In five cases a small quantity of fluid was withdrawn with the trocar, and of the list two died. A large quantity of fluid was found in four cases, but only 30 cms. was removed. He believes that the quantity of fluid is of high importance as an etiological factor.

ACUTE PUERPERAL INFECTION AND HYSTERECTOMY.—G. Berruti (*Giornall di Gin. e di. Ped.*) states that the mortality from puerperal infection when hysterectomy is done is greater than when ordinary therapeutic resources are resorted to, since, at the present day, the mortality by these means reaches only 10 per cent. In cases of infection without localization, the enormous mortality when hysterectomy is done, 76.5 per cent, proves that this kind of operation is not appropriate for the condition: Curetting, irrigation and injection of the serum of Mamorek give better results. Autopsy in the cases of hysterectomy, which show no localization of peritonitis, shows that the operation could not be of benefit in cases of general infection.

When there are remains of placenta or of membranes after abortion, hysterectomy is useful only when promptly executed and by way of the vagina so as to avoid diffusion of the infection. Late operation is contraindicated. The mortality under operation is very great. With localization of the inflammation in the periuterine tissue it is better to incise and drain the pus collection. In case of retention of the placenta, emptying and disinfection of the uterus are the appropriate means of cure. In cases of suppurating fibtromata, operative interference is a necessity, but such cases are not true cases of puerperal infection. Hence, the author concludes, that hysterectomy is not generally applicable to puerperal infection.—*Amer. Jour. Obst.*, June, 1905.

CESAREAN SECTION IN CASES OF CONTRACTED PELVIS BASED UPON A SERIES OF THIRTY CASES.—J. Munro Kerr (*Amer. Jour. Obst.* June, 1905), in discussing the question of sterilization of the woman, or removal of the uterus, states that the following rules express his feelings on the matter:

(1) A patient should be sterilized by hysterectomy if labor has been in progress for long, or if there is the probability of her having become infected. (2) A patient should be sterilized, and preferably by hysterectomy, if she has any organic disease, such as valvular disease of the heart, phthisis, etc., or if she is constitutionally very delicate. (3) With the good results now being obtained by Cesarean section, and especially in cases where the operation is repeated, strong, healthy uninfected patients should not be sterilized.

(4) As regards how often the operation is to be repeated, that is a matter which at present must be decided by patients and their medical advisers. He agrees with Whitridge Williams, that if a patient has undergone the operation twice or thrice, she should be sterilized.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Fever in Hysterical Persons.—Hyperthermia is, at times, real, at others artificial. In the former, it is due to some latent conditions which remained unrecognized; in the latter it is due to trickery, and was probably so in many cases reported as real. A close investigation demonstrated that hysterical women (mostly all fever simulators coming under observation were hysterical women) have a certain knack in handling the thermometer, when unobserved, to cause a rise of the mercury, confession and actual facts bringing to light that such artifices, as the following, will do so, namely: rolling the bulb to and fro between the index finger and thumb, rubbing it against the bedding, body or clothes, stroking rapidly and repeatedly the top end of the tube, applying the bulb to the hot water bags. When in the vagina the instrument is squeezed tight and made to rotate by movements of the thighs.

In from 12 to 20 seconds the preceding maneuvres result in from 5 to 6 degrees elevation.

Knowing this, we had better not allow the patient to handle the instrument and hold it ourselves in such cases. As a rule, simulators in addition to this artifice, will complete the symptom-complex by complaining of dyspnea, faintness, hemoptysis, vomiting, thus creating a picture of some real disease. But, luckily, the picture is always alike in all cases, so it may aid in detecting the fraud. Yet, we had better first go through a close examination of all the organs and apparatuses before calling a halt and laying bare the trickery.

How far some of these female simulators will go into the prosecution of their feigned plan is illustrated by the following report: For three months a hysterical woman managed to simulate hyperthermia by applying the bulb of the thermometer to her hot water bag, and this was known only through her own confession. Prior to this, she had simulated pains, vomiting and fever so well that she was operated upon for appendicitis, first; then for salpingitis; then again she received three intravenous injections of collargol and eight of normal salt solution, to all of which she most willingly submitted.

It can not but prove useful to remind such occurrences in our private hospital work. (*These du* Dr. Derksen, Paris).—*Journ. de Medicine et de Chirurgie prat.*

Uremic Hemiplegia.—Wilson (*Jour. A. M. A.*, July 1, 1905), in summing up conclusions, calls especial attention to the fact that by no means all cases that show insterstitial nephritis are subject to uremia, and to the still more important circumstance that neither sclerosis of the kidney, nor, in fact, arterio-sclerosis, predisposes to uremia until hypertension of the vascular system is superadded. The two by no means always go hand in hand. Many cases of high-grade sclerosis present a comparatively normal blood pressure. Certain cases of hypertension show little or no sclerosis and yet apoplexy occurs. Add to sclerosis of the arteries and veins hypertension, however, with the consequent intracranial tension due to this and to local toxic irritation, and we have present at once the ideal conditions for the causation of the uremic picture.

The ten cases treated entirely with a view to relieving pressure appear to warrant the following conclusions:

1. Various toxins are influential in producing the symptoms in various instances of uremia, the most important probably origin-

ating in an abnormal digestive tract or elsewhere, and resembling adrenalin in its action.

2. Intracerebrospinal overpressure, due to accumulation of fluid, causes the classical symptoms of uremia, and is often the dominant influence.

3. Spinal drainage, as a proof, often relieves uremia.

4. Occasionally when intracranial pressure has been removed, the toxin alone may cause the picture of uremia.

5. Uremic symptoms (other than coma) when due to intracranial pressure, may be either general or localized. The toxin acting independently of intracranial pressure, causes general and seldom paralytic phenomena.

6. Uremic hemiplegia and other paralyses are due to direct pressure, edema of the motor centers of the brain, and may be relieved by withdrawing cerebrospinal fluid.

7. Absence of general edema or edema of the external body while a high degree of intravascular and intracranial tension is present, affords striking suggestions.

8. Lumbar puncture with other means of reducing hypertension, viz.: free bleeding, free purging, free diuresis, large doses of aconite should be employed.

9. The ultimate cause of the vascular hypertension of uremia is yet unknown. It would appear that the intercranial fluid pressure is partly due to toxic inflammatory exudate, causing hypertension within the cranium, or throughout general circulation, or vice versa, the symptom complex arising from such a sequence of causes. Probably, uremia can not occur in the presence of low intrascular and intracerebrospinal tension.

10. Injections of small quantities of the cerebrospinal fluid from uremic subjects into healthy small animals, producing no deleterious effect, show that the toxic principle of uremia is not present in that fluid. It may possibly be found constantly present in small quantities in the normal blood serum (Hughes and Carter, 1893).

11. Lumbar puncture is not infallible, nor devoid of a slight risk to the patient, yet it should be made early and repeated if necessary to accomplish lowering of hypertension. It may save life. It often dissipates uremia, at least for the time being.

12. Transfusion of normal or other salt solution is harmful in uremia, by its mechanical and chemical influence, an increase of intravascular and intracranial tension, thus supplying conditions necessary to uremic seizure.

Department of Therapeutics.

In Charge of Dr. J. A. Storck, New Orleans.

Hypochlorization Method of Treating Epilepsy.—The hypochlorization treatment has been in use at the Massachusetts Hospital for Epileptics for several years. Morton has had 24 patients, who are either feeble-minded, idotic, or demented, on this treatment for two and one-half years. The diet of these patients has consisted mostly of milk, eggs, bread and butter, gruel and soups, to which has been added enough sodium bromide so that each patient received about 15 grains a day. Sodium chloride has not been entirely excluded from their diet. The results in this class of cases were very encouraging. The number of attacks decreased markedly, and the patients were much quieter than they were before the treatment was commenced. The hypochlorization method controls the convulsions, requiring only about one-half the amount of bromide usually given. It has little or no effect on the general nutrition of the patient, but is apt to cause constipation. It does not furnish enough salt to satisfy the patient's craving, but may be used with success with intelligent patients.

A modified salt-poor diet, in which about equal parts of sodium chloride and sodium bromide are used in food, may be used to advantage with idiotic and demented patients if their diet can be controlled absolutely. Bromism is comparatively rare.—*Journal A. M. A.* July 1, 1905.

Intoxication With Calcium Sulphid.—A young woman took internally some powder sold to apply as a paste for use as a depilatory. The symptoms were delirium, clonic convulsions, vomiting, cyanosis, small pulse, greenish-black formed stools and grayish-brown urine. The patient gradually recovered. The depilatory is sold under the name of "Haarfiend," hair enemy. It eats off the hair, leaving the spot as smooth as if shaved. Stadelmann frequently uses it to prepare animals for experiments. It is made, probably, by introducing sulphuretted hydrogen into quicklime, and these combine to form calcyum polisulphid or hepar sulphuris.—*Ibid.*—May 27, 1905.

TREATMENT OF TROPICAL AND ANKYLOSTOMA ANEMIA.—Liemberger practices at Levico, in Southern Tyrol, where there are famous arsenic-iron springs. He describes the symptomatic cure of a number of cases of tropical and ankylostoma anemia by the use of these waters. The systematic use of the Levico waters restored the patients to health, the blood findings becoming normal, even before other medication was attempted. His experience has further shown that tropical anemia, especially the malarial type, is promptly curable with the Levico waters, sustaining their traditional reputation in this respect. These waters, bottled, may be procured from pharmacists in America.—*Ibid.*

LIME IN TREATMENT OF TUBERCULOSIS.—Anguilli, of Naples, has accepted the theory of excessive loss of mineral elements as the main factor in preparing the soil for tuberculosis or in keeping it favorable. He therefore treats the disease by hypodermic injections of soluble lime salts. He has been exhibiting at Rome a number of patients cured by this remineralization, and is urging others to give it a trial. —*Journal A. M. A.*, July 1, 1905.

TREATMENT OF PERIODICAL VOMITING IN CHILDREN.—The numerous cases of periodical vomiting in children have convinced the author that this condition in children engenders a neuras thenic condition in adults.

The prodromal stage should be treated with 2 to 5 centigrammes of calomel combined with 50 centigrammes of bicarbonate of soda, repeated three or four times a day.

If the stomach is not too irritable, 30 to 50 centigrammes of sodium benzoate dissolved in essence of pepsine (*Brit. Pharm.*) and peppermint water may be added to the calomel.

If, during the attack, the child does not tolerate medicines administered by the stomach, enemata should be given, consisting of normal salt solution and bicarbonate of soda, the latter neutralizing the acids.

In serious cases where there is extreme prostration, the normal saline solution should be injected subcutaneously.—B. K. ROCHFORD.

Department of Nervous and Mental Diseases.

In Charge of DR. P. E. ARCHINARD and DR. ROY M. VAN WART,
New Orleans.

INSANITY AT PUBERTY.—Burr (*Journal A. M. A.*) calls attention to the importance of the recognition of insanity occurring in young persons. Previous to puberty we find persistent recurring somnambulism, outbursts of causeless violent anger, frequent night horrors and day horrors as evidence of mental instability. These should be corrected with the greatest care in the education of the child.

At puberty we find the mental disturbances approach the types seen in adults. Attention is called to the fact that much of the seeming viciousness is disease, and the great importance of its recognition as such. The normal disturbances occurring at puberty are mentioned. The healthy boy passes through it successfully, the others now commence to show signs of abrormal development. The commonest disturbance at this time is a simple dementia rarely recognized as a form of insanity. A boy formerly bright, active, intelligent, taking a great interest in sports, becomes slowly dull, loses his activity, and no longer takes the interest he formerly did. He no longer is the boy he formerly was, and he now continues his existence on a much lower mental plane. The result is a feeble-mindedness or a mild dementia.

Another type now shows a tendency to form vicious habits, to have outbursts of causeless anger, to be cruel, to chafe and fret under restraint, and lose self-control. Many of the criminal class belong here, who, while at first not considered insane, later in life end their days in an asylum.

The commencement of the disease known later in life as original paranoia, commences at this time. Five cases giving illustration of the character of the mental disturbance are related.

Attention is called to the differential diagnosis of these cases from hysteria. A careful examination of the field of vision will often settle this point.

He concludes with the following words: "The proper treatment of insanity at puberty is prevention; in other words, education. When we pay more attention to teaching self-control and clean morals, when those whom nature intended to lead a quiet life do not try to lead the strenuous life, and when parents get wisdom, insanity will greatly decrease. But these things are in the very distant future."

ALCOHOL DELUSIONS.—Crothers (*Medical Record,* July 1, 1905) calls attention to the frequency of delusions in persons addicted to the use of alcohol and the danger of allowing these patients to go at large. He relates the case of a lawyer of great prominence who became suspicious of the fidelity of his wife. This became so offensive that a physician was consulted. The physician remonstrated with him to no purpose. Later he consulted with another physician, who informed it was a delusion. He then employed a detective and spent most of his time hunting up imaginary clues. He now confided to his family physician that he would shoot any one under suspicious circumstances. He was advised to take a trip to Bermuda, but returned on the next steamer. He then went to the club to live. His wife now had him examined by two physicians, who refused to certify him insane. She now left him and went to a distant part of the country to live. Shortly after he shot at a servant girl. Again he was examined and his explanation was so plausible that they refused to consider him insane. Crothers expresses the opinion that he was an alcohol maniac, and that he was insane. He was addicted to the use of alcohol, and for the previous ten years he had used spirits regularly. He went on a sea voyage and disappeared one night and was not seen again. He left a will leaving all his property to his wife.

A second case of the brother of a physician who had accumulated a fortune by careful work. During the last ten years of his life he had used spirits regularly. Suddenly he accused his wife of being untrue to him, and after accompanied them with threat. His wife and three children tried to reason with him with no result. He was examined by two physicians who declared that it was only a family quarrel with no sign of mental disturbance, and advised a trip. The wife was with some difficulty persuaded to go. Ten days later they were both found dead in a bed at a hotel. The third case was one of a similar nature in which a man of wealth, after drinking half a life time in so-called moderation, suddenly became convinced that his wife was plotting against him. Later he shot at a grocery clerk with whom he saw his wife talking. Rushing into the next house he shot himself. After discussing these cases he draws the following conclusions: (1) The continuous drinker of spirits in active life is cultivating a soil for the growth and development of distinct psychoses, which may break out at any time. One of the most common of these symptoms is delusions of infidelity. (2) Delusion of persecution and delusion of grandeur, together with manias of various kinds, are natural sequels of alcoholic degeneration, and should receive the most careful study. (3) All such persons are irresponsible—to what degree the facts of each case must determine.

Department of Ophthalmology.

In Charge of Drs. Bruns and Robin, New Orleans.

THE TREATMENT OF INTERNAL OCULAR INFLAMMATION BY DIAPHORESIS.—At a meeting of the Section on Ophthalmology of the College of Physicians of Philadelphia, Dr. H. F. Hansell read a paper on *"The Treatment of Internal Ocular Inflammation by Diaphoresis,"* describing two cases of acute choroiditis and one of chronic uveitis in which the remedial effect of sweats was marked. The first was that of a man weighing 234 pounds who had lost the vision in the left eye until only L. P. remained. In the choroid just above the foveal region was a dense mass of pigmented exudate and the vitreous was filled with fine opacities. The patient's weight was reduced 29 pounds after twelve successive hot baths and profuse sweating, and the vision was restored to the full acuity in twenty-one days. The second case closely resembled the first in the nature of the affection and in the prompt and complete recovery. The third was less tractable, the man having suffered with a low grade uveitis for eighteen months. The final result, however, was equally satisfactory. The writer relies mainly upon the hot bath, hot-water bottles, and blankets for the induction of the sweat and reserves pilocarpin for patients who do not readily respond to the simpler treatment. In conjunction with the sweats he recommends the use of mercurial inunctions and, after the patient has regained his liberty, the administration of potassium iodid.

Department of Ear, Nose and Throat.

In charge of **A. W. DeRoaldes, M. D.**, and **Gordon King, M. D.**, New Orleans.

The Use of Perborate of Soda in Suppurative Otitis.—Maurice Bloch, of Paris, calls attention to the advantages of this preparation over hydrogen peroxide in the treatment of suppurative conditions of the ear. Perborate of soda is simply a combination of borax and hydrogen peroxide, in powder form, and when dissolved in water gives off hydrogen peroxide in nascent form. It is used as a dry dressing in ear suppuration, and being alkaline, does not macerate and excoriate the delicate lining of the ear canal as does the usual preparation of peroxide, while at the same time it decomposes the pus secretion and acts as a strong deodorant. By absorbing the secretions coming from the middle ear it protects the ear canal from secondary inflammation, which is often a very painful sequel of middile ear suppuration. The author reports a few cases in which he has based his conclusions in favor of this drug.—*Archives Internat. de Laryngologie, d'Otologie, etc.*. May-June, 1905.

Photo-Therapy in the Treatment of Non-Suppurative Otitis Media.—T. Mangioli, of Rome, is at present engaged in the treatment experimentally of a number of cases of dry middle ear catarrh by means of a modified Finsen light, and in a preliminary report of his work speaks of being encouraged with the results thus far. The treatment is based on the belief that the chemical rays produced by the apparatus have, besides their bactericidal property, the power of exalting the life and energies of the tissues, and thus of combating those morbid changes that take place in the middle ear and cause deafness. Care must be exercised, however, to avoid causing a painful dermatitis from too long an application of the light. The final report of this treatment is to be awaited with much interest, and with the sincere hope that at last something has been found to overcome this most obstinate condition.

UNUSUAL CASE OF FOREIGN-BODY IN THE LARYNX.—Noury, of Constantinople, relates the case of a child six years of age who was taken with an attack of suffocation and cold while eating soup. The respiration improved in a short while, however, and remained good until ten days later, when dyspnœa supervened and tracheotomy had to be performed. Nothing in the way of a foreign body could be seen in the larynx, which appeared inflamed and œadematous. Feeling sure that such was the case, however, the author performed laryngo-fissure and discovered a small piece of egg shell imbedded in the larynx, giving rise to the swelling that caused the stenosis. The X-Ray had been used, but showed no sign of the body. The child eventually made a good recovery.

Louisiana State Medical Society Notes.

In charge of DR. P. L. THIBAUT, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr. J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First St., New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist., Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. District, Sunset.

(Continued from July Number.)

REPORT OF THE COUNCILLOR FOR THE SIXTH CONGRESSIONAL DISTRICT, was then read by the Councillor, DR. C. M. SITMAN,

As Councillor for the Sixth Congressional District, I beg leave to submit the following report: This District is composed of the Parishes of Ascension, East Baton Rouge, West Baton Rouge, Point Coupeé, Iberville, East Feliciana, West Feliciana, Tangipahoa, Livingston, Washington, St. Helena and St. Tammany, comprising twelve in number. Eight of these parishes, namely: Ascension, East and West Baton Rouge, Iberville, Tangipahoa, Point Coupeé and St. Tammany have a regular chartered Parish Medical Society. East and West Feliciana have a consolidated society. St. Helena, Livingston and Washington Parishes have not been organized, and I have the same to contend with this year as I had before, these parishes not having enough of the right kind of material and the few who would favor a society are too far apart, and some complain of old age and it is now with them too late to get a hustle on. My parish, St. Helena, is a small inland parish, and we have not a sufficient number of qualified physicians to organize a society. So five of us affiliate with Tangipahoa, our nearest society.

I have recently met with some encouragement in Washington Parish, so I had the *Franklinton Era* to insert a notice that I wished all the practicing physicians of Washington Parish to meet me at Franklinton on Monday, 1st inst., for the purpose of organizing a parish society. This is about forty miles from my home through the country and no railroad. Unfortunately the rains poured and the creeks and river became unfordable, and so ended the appointment. I have not heard from them since, but I am satisfied but few could turn out that day. My letters have frequently visited Livingston Parish and so far have never met with any encouragement. The licensed practitioners there are so few and far apart, and if all could be rallied, it would then be a very small society. Livingston Parish is well filled up with quacks and humbugs and it seems its citizens are reconciled to it.

I would advise some of our young, hearty and healthy graduates who are just starting out this season to locate there and soon root out these charlatans; it would be a Christian act for these citizens who have been imposed upon so long.

C. M. SITMAN, M.D.

THE REPORT OF THE COUNCILLOR FOR THE SEVENTH CONGRESSIONAL DISTRICT, was then read by the Councillor, DR. C. A. GARDINER.

MR. PRESIDENT AND GENTLEMEN: The condition of the profession in the Seventh District, composed of Acadia, Avoyelles, Calcasieu, Cameron, Grant, Rapides, St. Landry and Vernon is pretty healthy from an organized point of view. There is a society in every parish except Cameron, which has only two regular physicians in the parish. In some of the parishes, notably Avoyelles, Rapides, Vernon and St. Landry, which has recently revived, but still has plenty of room for improvement, the societies are pretty active; in others they are somewhat lukewarm. Grant has recently joined us with a solid foundation and promise of a good society. The condition in the District, simmered down, is about this: Avoyelles, Grant, Rapides and Vernon are holding down their side, with still some room for more development, whereas Acadia, Calcasieu and St. Landry are somewhat lukewarm, with plenty of room left for development. Respectfully,

C. A. GARDINER, M.D.
Councillor Seventh District.

Sunset, La., July 9, 1905.

DROPPING DELINQUENT MEMBERS FROM THE ROLL.

THE PRESIDENT: On account of the condition reported by the Secretary, it will hardly be necessary to take any action under this head.

ELECTION OF APPLICANTS FROM UNORGANIZED PARISHES.

DR. J. A. GAAR, Weston, Jackson Parish, stated that his parish was unorganized, and that he desired to apply for membership.

THE PRESIDENT: As we have no specific regulation covering the point, the Chair would suggest that the name be referred to the Councillors for a report.

DR. JOACHIM made a motion that the name be referred to the Councillors. The motion was duly seconded, and carried.

READING LIST OF COMPONENT SOCIETIES IN GOOD STANDING.

The President stated that that had practically been done already in reading the reports of the officers.

REPORTS OF STANDING COMMITTEES.

The President stated that the report from the Executive Committee would be passed, as the Society had already had practically a complete report from the Society.

COMMITTEE ON SCIENTIFIC WORK.

The Secretary said that the Committee on Scientific Work offered the program for the 1905 meeting as its report .

ON PUBLIC POLICY AND LEGISLATION.

The Chairman of this Committee, DR. CHARLES MCVEA, read the following report:

GENTLEMEN: Your Committee on Public Policy and Legislation beg leave to report the following: The amendments to the Act creating the State Board of Health which passed both Houses of the Legislature during the session of 1902, were practically unconstitutional, although not declared so by the courts. This was due to an omission in the enrolling room, which was overlooked by every one through whose hands the bill passed. The omission was in Section 4 of the Act, and to correct this error a bill was introduced at the last session by Judge Thorpe which passed both Houses and was signed by the Governor on July 7th, 1904. This is Act 184 of 1904, amending Act 150 of 1902.

A bill was introduced by Dr. Smart, of DeSoto, to amend certain sections of the law creating the Board of Medical Examiners. These amendments you all are familiar with, as they were discussed freely at our last meeting. After quite a stubborn fight, this last bill was defeated by only one vote in the Senate. The vote stood twenty for and fourteen against. The defeat of this bill was due entirely to the so-called opticians in New Orleans, who protested in the committee room and on the floor of the Senate, that if the bill passed, it would be impossible for them to "mend a pair of eye-glasses without a prescription from a physician." How they figured this out, I do not know, as it never showed on the face of the bill, and I am sure, never entered the minds of any of its proposers. CHARLES McVEA.

May 9, 1905.

THE REPORT OF PUBLICATION COMMITTEE was read by the Secretary.

NEW ORLEANS, May 9, 1905.

GENTLEMEN: Your Publication Committee begs to report that the Transactions for 1904 were published in the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL. We submit below a copy of the communications bearing on the subject, which fully explains the matter.

Only one paper was withdrawn by the author and another read by title was not furnished the committee; the others were published in the order in which they were presented to the committee.

We have found this method of publication satisfactory and beg to recommend its continuance. Respectfully submitted,

P. F. THIBAUT, M.D., *Chairman.*

REPORT OF SPECIAL COMMITTEES.

THE REPORT OF THE COMMITTEE TO STUDY CHANGES IN THE CONSTITUTION was read by the Secretary, DR. THIBAUT.

NEW ORLEANS, May 3, 1905.

To the President and Members of the Louisiana State Medical Society.

GENTLEMEN: Your Committee on Changes in the Constitution desires to report unanimously: That it believes the present Constitution best adapted as it stands to the needs of the profession in our State and it does not therefore recommend any changes. That it believes the Committee on Nomination (Chap. IV., Sec. 2, By-laws) as now constituted is too small and should be increased to two members for each Congressional District of the State. That it believes the choice of the Nominating Committee, for many and obvious reasons, should remain in the hands of the members of the Society and should be *elected* by the members of the Congressional Districts present at the annual meetings.

That the By-laws would be improved and made clearer by embody the following changes:

1. On p. 9, Art. 6, Sect. 3, limits eligibility to office; therefore, By-laws, Chap. I, Sec. 1, should mention such limitations.

2. By-laws, Chap. I, Sec. 4, should read: "Each member in attendance at the annual session, or any special session, shall enter his name," etc.

3. By-laws, Chap. III., evidently provides for annual meetings and the word annual might well be inserted.

4. Chap. V., Sec. 3, directs that the Treasurer "shall subject his accounts to such examination as the Society may order"—and "shall charge upon his books the assessments against each member at the end of the fiscal year." Would it not be better to order a formal auditing of the Treasurer's books annually and to direct the charging of assessments as soon as they become due?

5. In Chap. VIII., Sec. 1, "ten days in advance" should read "sixty days" in order to afford the officers ample time for the preparation of proper reports.

6. Chap. XI., Sect. 11, should read 60 days instead of "30 days"—for the same reasons.

Very respectfully,

HENRY DICKSON BRUNS, M.D., *Chairman.*
WILLIAM M. PERKINS, M.D.,
J. M. BARRIER, M. D.

THE CHAIRMAN OF THE COMMITTEE ON THE BEST METHOD OF PREVENTING THE INCREASE OF INSANITY, DR. G. A. B. HAYS, then read the report of his committee.

MR. PRESIDENT AND FELLOW-MEMBERS OF THE STATE MEDICAL SOCIETY: At the annual meeting one year ago a resolution was adopted requiring the President to appoint a committee whose duty it should be to investigate and report at this session of the Sociey upon the question: "What can be done to prevent the increase of insanity?" Mark you, gentlemen, I say "question," and it is a question of such grave moment and of such vital importance to the entire civilized world that it is amazing, and I use word advisedly, that it has received so little attention from the medical profession and from the law-makers of our country.

About two months ago I was notified by your Secretary that I had been selected by your President as chairman of a committee of three to make a report at this session. The time given for preparation reminded me of the anecdote of the young lady who occupied a seat next to Baron Von Humboldt at a dining; who, when the table was being cleared before the dessert was brought on, turned and said to him: "Now my dear Baron, we will have five minutes time, please give me the history of the physical world."

However, I promptly wrote to my colleagues on the committee and begged them to transmit to me before the next meeting of the Society the results of their investigations and labors in that direction, in order that we could be enabled to submit a report, but with a unanimity that was to be admired for its solidarity they failed to reply, due no doubt to the naturally anesthetic state of the human mind, from which even the medical profession is not exempt.

I have been met from other directions with expressions upon the subject which would incline me to the belief they were all named "Thomas," they were so prolific of doubts as to the feasibility of anything being done. And yet, gentlemen, when we consider the gravity of the situation, the fact—and it is a fact—that insanity is increasing in greater ratio than is the population; that millions of money are being expended annually to care for the insane, whose infirmity precludes their caring for themselves, and greatest of all the thousands of homes that are shadowed over by this great calamity, is it not time to pause and reflect that as medical men, men who are looked to to conserve the health of our people, is it not our duty,—our solemn duty—to get together and endeavor to put a check upon this rapidly increasing menace.

What *can* be done to prevent the increase of insanity? Much might be accomplished by a general system of education upon the part of the medical profession. Let the family physician advise in reference to bringing up, and the mental and physical training of the younger members of the family, especially those having a tendency toward neuroses. The two contrasting types of such children, this mischievous, morally deficient, perverse, often precocious child; and the slow, moping, morose, stupid and forgetful one, are the raw material out of which the finished insane product is afterwards manufactured by the malicious machinery of our ill-regulated social factory. These children should have no complex environments, no forced stimulation in the matter of education that is so commonly made a part of their lot. They should be made to lead the simple life. These psychopathic individuals should be kept in those spheres of work for which they are adapted, and out of the stress and strenuousness of professional and intellectual pursuits that are beyond their capacity. These tainted individuals are constitutionally unfit to marry and reproduce their kind, and some prohibition, both advisory and legal, should be required. While it is true that any interference with the assumption of the marriage relation has hitherto been considered beyond the province of government, state or national, the time is rapidly approaching when it will become an imperative necessity. It is the duty of government to endeavor to prevent the development of psychoses just as much as it is to prevent the invasion of, and spread of, pestilence. The State of Louisiana in legislating against marriages of consanguinity, prohibiting the marriage of first cousins, has done well and taken one small step forward in this direction. More information, both theoretical and practical, should be possessed by physicians when they are graduated, upon the subject of insanity and degeneracy, and greater attention should be given it in our medical schools. Necessarily this process of education would require much time to be productive of results, but had the effort been made many years ago, results would have been apparent now.

What are the great, prominent factors in the production of insanity? Briefly summarized we may say alcoholism, drug addiction, syphilis and heredity, and the greatest of these is heredity. Education will go far towards lessening the evils wrought by the first three named, and should do much to reduce the train of disaster that follows in the wake of the latter, more especially if accompanied by appropriate legislation that can be enforced and made effective.

From time to time, in the discussion of the subject of preventing the increase of insanity and other degeneracy, drastic measures have been suggested and advocated. In 1897 a bill was introduced in the Michigan legislature which provided: "Section 1. That all persons inmates of the Michigan Home for the Feeble Minded and Epileptic and all persons who shall hereafter become inmates of said Home for the Feeble Minded and Epileptic, that each and every person confined in said institution and before he or she is discharged shall be caused to submit to an operation that causes asexualization, that such persons shall cease to be able to reproduce their kind."

"Section 2. All persons who shall have been convicted of a felony a third time and so stated by the Court, the first or second conviction having been committed in this state or some other state of the United States, upon conviction and sentence to a Michigan State Prison, all of such persons so convicted and sentenced at a time prior to the expiration of such known third sentence shall be caused to submit to an operation that causes asexualization and stops their ability to reproduce their kind."

* * * * * * * *

"Section 5. That whoever shall have been convicted of the crime of ravishing a child or woman while upon the streets of any city, village, public highway or any other place within the state, it shall be the duty of the judge making such sentence, to include in such sentence that within one year after being confined in such prison an operation which causes asexualization shall be performed as provided in Sections 3 and 4 of this act."

Dr. Stuver, of Texas, considered both the criminal and the defective division of this subject under the title: "Would Asexualization of Criminals, Sexual Perverts and Hereditary Defectives Benefit Society and Elevate the Human Race?" He states that it would: 1st. By removing or modifying their exciting causes and favoring circumstances it (asexualization) would greatly limit the dissemination of disease, vice and crime. 2nd. It would furnish a humane and rational punishment for a large and continually increasing number of criminals and satisfy the demands of justice. 3rd. Owing to the innate repugnance towards this condition, it would be a powerful deterrent, and thereby limit the prevalence of crime, and protect society against the criminal. 4th. By removing the procreative capacity of defectives and criminals it would do more to diminish their numbers, and protect society against their ravages, while at the same time raising the physical, intellectual and moral standard of the race, than all other punishments combined. 5th. It would be the humane and rational method of treating these classes, because it would protect them against harsh and brutal punishments, and by removing the cause of their obliquities transform many of them into useful and productive citizens."

Dr. Evarts, of Ohio, in a paper on "Asexualization as a Penalty for Crime and the Reformation of Criminals," urged the asexualization of all convicts (inclusive of both sexes) whose crimes circumstantially considered, indicated a constitutional depravity transmissible by descent from parent to offspring. He said: "Public sentiment might not sustain such an innovation. The public sentiment of the future is destined to be more and more informed by science, and will eventually adopt its suggestions in matters of state-craft and social economics, including criminal jurisprudence, as well as all other affairs of life. This world with its inhabitants is gradually but surely moving ever on and up toward the greater light, and men of intelligence and learning realize the fact that with every step taken vision becomes clearer and more comprehensive, and positions may be occupied today with safety that but yesterday seemed to be dangerous, if not inaccessible." As has been pointed out by Dr. Eastman, of Kansas, "There is not a greater point of difference between savage or semi-civilized nations and those which are now enlightened and Christianized than the way they treat defectives. It is conceded that the lower scale of development produces a smaller proportion of defectives than does the higher; but this will not account for the scarcity of defectives among the savage nations. When the rude solons of savagery, or the intensely practical mandarins of a higher but peculiar civilization are confronted with the problem of defectives, they adopt a practical application, of the *'cui bono'* theory, and requires no almshouses or asylums. They knock their old men in the head and pitch the youthful defectives into the water, or gathering euthanasia from the poppy hasten the exit of defectives by methods less brutal but no less sure," thereby, I may mention, laying the foundations for our modern Oslerism.

Physical, mental and moral attributes are derived from progenitors and ancestors with more or less variation in intensity. Defective and criminal persons are very commonly attracted to their like, and, except for certain conservative efforts of nature, would soon over-run the earth.

The tendency of our Christian civilization, tending to the preservation of defectives and criminals, imposes very heavy burdens. It is unnecessary to dwell upon this proposition, to instance the "Jukes" family, or to demonstrate the prominent and pervading effect of heredity. None will cavil or question these points, none will withhold consent to the statement that we are burdened with an over-production of defectives and criminals. We go on building asylums, hospitals, reformatories and prisons, and we keep them full. Imbecility, idiocy, insanity, epilepsy, deafness, blindness, incorrigibility, youthful waywardness, adolescent vice and immorality, and adult criminality multiply apace in the land, and, startled and affrighted, well may we ask: "Can society successfully organize to prevent this most threatening and dangerous over-production of defectives and criminals?"

Mrs. Sallie A. Cotton, of North Carolina, in a paper on "National Training for Women," says: "Scientific motherhood means more than the thought can grasp. It means the reformation of the drunkard, the redemption of the criminal, the repentence of the murderer, the abolition of the asylums for the blind, dumb and insane!" But Dr. Eastman says truly that is but half of the question. "*Fatherhood* needs developing along lines not only scientific, but along lines of purity and morality. Society of almost every grade expects the wife to bring purity and innocence to her marital responsibilities, but it is permitted to the husband to have sown wild oats and to have reaped disease well-nigh sure to be transmitted to wife and child. The Mothers' Congress limited its discussion to scientific motherhood, but untainted fatherhood is equally important, and should receive equally studious consideration from the paternal sex, if improvement in the race is sought.

"Society can begin, something can be done; but obstacles are so varied and so powerful that neither 1925 nor 2025 may see the work accomplished. It is true the 'hill-tops of science are luminous,' but the valleys are deep and dark. It is not wise to hold out expectations which cannot be realized. But something can be done.

Let all these concomitant conditions have careful and scientific, not sensational, consideration. Public sentiment must not be violently strained. Confidence is a plant of slow growth. As scientists, we can have no sympathy with lurid demagogical utterances of political speakers. As conservators of an intelligent and healthy public sentiment, which will gradually compass the best interest of the race, we cannot advocate such wholesale indiscriminate asexualization of criminals and defectives as has been proposed. Such radical and extreme measures would result in revulsion and uprising against the whole project. What can best be done?

"Having given this subject much thought, having felt the pulse of the public in both the radical and conservative arteries, and having for many years been connected with the care of a certain class of defectives my conclusions are as follows:

"1. Asexualization of criminals and defectives, and those who have inherent tendencies to the production of these classes would result in great improvement of the human race.

"2. The practical difficulties which would be encountered in attempting to carry out this theory, with that disregard of fear or favor necessary to its success, are at present insurmountable.

"3. These difficulties can only be surmounted by a slow process of education in which scientific motherhood, untainted fatherhood, the same code of morals for both sexes, the universal acceptance of the golden rule, and the utter subordination of the individual to the welfare of the public, are foundation principles.

"4. When such education of the world shall have been accomplished, the millennium will be at hand."

Gentlemen of the Louisiana State Medical Society, what are you going to do about it?

(TO BE CONTINUED.)

Medical News Items.

THE AMERICAN PROCTOLOGIC SOCIETY had its seventh annual meeting in Pittsburg, May 5 and 6, 1905, and elected the following officers: President, Dr. Lewis H. Adler, Jr., of Philadelphia; Vice-President, Dr. George B. Evans, of Dayton; Secretary-

Treasurer, Dr. A. B. Cooke, of Nashville. The Executive Council: Dr. J. R. Pennington, of Chicago, Chairman; Dr. T. H. Martin, Cleveland; Dr. Wm. M. Beach, Pittsburg. Time and place of meeting to be determined by the Council.

THE LOUISIANA STATE UNIVERSITY AT BATON ROUGE proposes next session to inaugurate a preparatory course for medical students. This will embrace bacteriology, histology, embryology, anatomy, materia medica, toxicology and chemistry. Especial attention is to be paid to the German and French languages, and the whole course is to be arranged so as to bear upon the preparation of students for subsequent instruction in medicine.

THE HOT SPRINGS MEDICAL PROFESSION has been somewhat upset over the recent decision of the Arkansas Chancellor to the effect that the act of the State Legislature restricting "doctor drumming" was unconstitutional. Along this line it is reported that the United States Government has sent a special inspector to investigate the conditions of medical practice there and also of the presence of wholesale gambling. It is rumored that in order to rehabilitate Hot Springs the Government will put certain restrictions and regulations upon the use of baths so as to purify the general morale of this popular resort.

THE NEW ORLEANS BOARD OF HEALTH has issued a very creditable mortality report for the month of June. The general scheme of this report follows that published by the authorities of Chicago and San Francisco. The report gives in particular detail a statement of the relative white and colored mortality according to the Bertillon classification. The officers of the Board are to be complimented upon the lucid manner in which they present their interesting report.

THE FIFTEENTH INTERNATIONAL MEDICAL CONGRESS.—Plans are maturing for the engagement of a chartered steamship from New York at a reasonable rate, and to include not only passage to the Congress at Lisbon, but also a European itinerary. Dr. Charles Wood Fassett, of St. Joseph, Missouri, is engineering the arrangement.

THERE WERE 123 DEATHS FROM HEART DISEASE in New York City in one week recently, as against 58 in the corresponding week in 1904.

THE LABORATORIES OF THE STATE AND CITY BOARDS OF HEALTH, in charge of Dr. P. E. Archinard, have been removed to the New Orleans Polyclinic Building, No. 1403 Tulane Avenue. Doctors should make a note of this, and send their specimens there for examination.

A WOMAN PROFESSOR OF JOHNS HOPKINS.—Dr. Florence R. Sabin has been appointed associate professor of anatomy in Johns Hopkins University. She is a graduate of Smith College and of the Johns Hopkins Medical School.—*Exchange.*

ILLEGAL LICENSES TO PRACTICE IN OKLAHOMA.—Owing to a change in the regulations concerning the practice of medicine, trouble has arisen over a large number of licenses recently granted in Oklahoma. Prior to March 12, 1903, graduates of recognized colleges of medicine were granted licenses to practice in Oklahoma upon the presentation of their diplomas and the payment of a fee of $2. Since that time licenses have been granted only upon examination. During the interval of nineteen days between the time the new law became effective and the time when the new Board of Health was organized 180 licenses were issued to applicants. P. C. Simons, the territorial attorney general, holds that the old law was not operative when these licenses were granted and that they are illegal. It is alleged that circular letters were sent to different medical colleges advising them that they should take advantage of the opportunity of having their graduates licensed to practice before the law was in force. The 180 physicians will be required to take the regular medical examination or discontinue their practice in Oklahoma.—*Exchange.*

PERSONALS.—Dr. Amedeé Granger has been appointed one of the members of the American Committee of the first Congrès International of Physiotherapie, at Liege, August 12 to 15.

DR. E. M. HUMMEL, recently assistant at the Jackson Insane Asylum, sailed for Liverpool during the month of June. The Doctor expects to spend several months in European centres.

DRS. F. W. PARHAM, E. D. MARTIN and CHARLES CHASSAIGNAC left for a vacation which will include attendance at the American Medical Association meeting.

DR. S. R. MALLORY KENNEDY, formerly of this city, and now of Pensacola, Fla., has recently been appointed Assistant Acting Surgeon in the Marine Hospital and Public Health Service.

DRS. H. B. GESSNER, O. L. POTHIER and J. D. MARTIN have returned from Baltimore, where each has been engaged in special study.

DR. P. E. ARCHINARD has been made Associate Professor on Diseases of the Nervous System in the Medical Department of Tulane University, and DR. O. L. POTHIER has been made Demonstrator on Bacteriology.

DR. S. P. DELAUP has been elected Professor on Genito-Urinary and Rectal Surgery in the New Orleans Polyclinic.

DR. JOSEPH SCOTT has been appointed Examining Surgeon in the United States Public Health and Marine Hospital Service, and detailed to the United States Immigration Station under Capt. P. H. Stretton.

DR. I. N. ADAMS has removed from Campti, to Trout, La.

DR. A. J. SMITH, of Franklin, La., has moved to Salao, State of Guanajrato, Mexico, care Mexican Central Railroad.

DR. J. A. TUCHER has moved from Donaldsonville to Baton Rouge, La.

DR. A. M. HUGHES has moved from Rosepine to Orange, La.

MR. ADAM WIRTH has been appointed a member of the Board of Pharmacy. He graduated from Tulane in 1897, has spent three years in Philadelphia, and was four years in the Chair of Pharmacy at Tulane, which he resigned to enter the drug business.

DR. G. A. B. HAYS has been transferred from the Insane Asylum, Jackson, La., to the Pineville branch, and DR. CLARENCE PIERSON has been appointed Superintendent at the Jackson Asylum.

MARRIED.—DR. PAUL H. TETREAU, of Larose, La., to Mrs. Mary D. Harang, on June 27, 1905. The ceremony took place in New Orleans.

DR. GEORGE M. TICHENOR, JR., and Miss Gertrude Belknap, June 28, in New Orleans.

DR. WILLIAM HUPP BALDWIN to Miss Theodocia Rogers, June 28, in Memphis.

DR. P. ALBERT MOORE to Miss Louise Gibbons. The wedding took place on June 30, at the Jesuits' Church, in New Orleans.

SURGERY, GYNECOLOGY AND OBSTETRICS is the title of a new journal to be published monthly by the Surgical Publishing Co. of Chicago. The editors are Drs. Franklin H. Martin and Allen B. Kanavel, both of Chicago. The collaborating staff includes a number of prominent men in each of the titular branches of surgery. The initial number, for July, is a creditable presentation of the subjects which are to constitute the scope of the publication. Editorials are all signed and the general appearance of the new periodical is clean and attractive.

THE TEXAS STATE JOURNAL OF MEDICINE has made its initial appearance as the organ of the Texas State Medical Association, with its domicile at Forth Worth, and under the editorial direction of Dr. Ira Carleton Chase. The councillors of the fifteen districts of the Association make up the collaborating, or associate editorial staff. The current issue consists of 3,700 copies. The establishment of this journal witnesses the demise of the *Texas Medical Gazette,* of Fort Worth, and the *Eighth District Medical Bulletin.* The *Journal* feels assured of success in its enterprise, as the Association membership guarantees a circulation of 2,520 subscribers, which the management believes it is justified in expanding to a circulation of 3,000.

A considerable amount of matter is published in the initial number and at the end of the issue there appears a complete list of the present membership.

Texas never does things half-way, and we feel sure that the *Journal* has come to stay. We extend the hand of fellowship to the editor, already no novice in the art, and to his collaborators, who, with him, promise a clean, wholesome, readable publication as the exponent of the medical doings of the Lone Star State.

Book Reviews and Notices.

Modern Clinical Medicine—Infectious Diseases. Edited by J. C. Wilson, A.M., M.D. An authorized translation from *Die Deutsche Klinik* under the general editorial supervision of Julius L. Salinger, M.D. D. Appleton & Co., New York, 1905.

As stated by Professor Salinger, Leyden and Klemperer have gathered in *Die Deutsche Klinik* the views of the most eminent German clinicians of the present day.

The work contains a complete list of all diseases which are now recognized as infectious. Articles on vaccinia, varicelia, dengue, yellow fever, Weil's disease and Malta fever, not contained in the German publication have been written by the editors in order to present a complete work on infectious diseases. We fully agree with Prof. Wilson that the "*Deutsche Klinik,* the name of the collective labor of the master minds of medicine in Germany, stands as a summary of existing knowledge and as a permanent record of the medical science of our times, in the foremost rank."

To mention the names of the writers is presenting a list of distinguished specialists—Leyden, Klemperer, Löffler, Furbinger, Ortner, Leubner, Baginsky, Eichhorst, Jurgensen, Rumpf, Penzoldt, Nicolaier, etc., etc.

The volume opens with a paper on typhoid fever by Klemperer and closes with one on actinomycosis by Nicolaier—passing through the whoel list of the infectious diseases. It is difficult to select any of the articles for special comment, but we may say that all, practitioner, student and secular, will find valuable information.

Prof. Wilson and Prof. Salinger deserve the highest praise to make this work accessible to the English speaking profession, and it affords me the greatest pleasure to recommend it most warmly. It is the work of men some of whom I know personally and some of whom have been my teachers. Lerch.

The Medical Epitome Series—Clinical Diagnosis and Urinalysis. By James Rae Arfeill, A.B., M.D. Lea Bros. & Co., Philadelphia and New York, 1905.

Of the little book it may be said that the author has carried out his aim to present a practical guide to physicians who are not familiar with laboratory methods and to students. The little work is well adapted to undergraduate work—questions being added to each chapter. Lerch.

Gynecology. Medical and Surgical. Outlines for Students and Practitioners. By Henry J. Garrigues, A.M., M.D. J. B. Lippincott Co., Philadelphia and London, 1905.

This work is not an extensive treatise on gynecology, but rather a book for students and practitioners who desire to make themselves acquainted with the essentials of modern gynecology. As Dr. Garrigues expresses it, "It is an outline of the whole system of gynecology, calculated to be a guide for beginners." Anatomy, embryology, rare diseases, and unusual operations have been omitted. Dr. Garrigues' long and extensive experience entitles his book to a high standing as a concise hand-book on gynecology. Miller.

Malformation of the Genital Organs of Woman. By CH. DEBIERRE, Paris, translated by J. HENRY C. SIMES, M. D. P. Blakiston's Son & Co., 1905.

This timely little volume of 182 pages gives a fair index of the efforts of workers of the past few years to rescue this subject from the ridiculous superstitions and morbid curiosity which have for so long dominated the field of teratology. Now that we know that monstrosities are the result of accidental causes which modify or arrest portions of the organization during development, and since it has been demonstrated that it is possible to modify by the action of internal physical causes the evolution of a fecundated germ and that all malformations are phenomena of the same order, we may expect a rapid growth of interest in scientific teratology.

The work can be recommended to anyone desiring information on this subject. MILLER.

The Diagnosis of Diseases of Women. A Treatise for Students and Practitioners. By PALMER FINDLEY, B.S., M.D. Second edition, revised and enlarged. Lea Bros. & Co., Philadelphia and New York, 1905.

This is a volume unusually well illustrated and originally arranged, devoted strictly to the diagnosis of affections of the genito-urinary organs of women. Naturally, one would expect to find the bacteriological and microscopical aids to diagnosis fully exploited in such a volume, and in this there is no disappointment. Full scope has been given in the text and in illustrations to pathology, and the necessity of a thorough knowledge of microscopical technic in gynecology is conclusively shown.

Another feature of interest is the historical and etiological outlines which appear as an introdutcion to the chapters.

This is the second edition of Dr. Findley's book and among the additions are noted new chapters upon blood and bacteriological examinations and the latest views upon subjects still in dispute, such as cystic degenertion of the ovaries, chorio-epithelioma malignum, and diseases of the ureters and kidneys. It may be safely stated that no work of the present day is of more importance to both general practitioner and the specialist as this book of Dr. Findley's. MILLER.

A History of Laryngology and Rhinology. By JONATHAN WRIGHT, M.D. Wright, Matthews & Co., Pubs., St. Louis.

One of the most interesting and instructive works that has appeared in medical literature of recent times is this volume recently published treating of the nose and throat in medical history, by Jonathan Wright, of Brooklyn. This able writer has expended much time and energy in carrying out the research work necessary for the completion of this difficult task, and the profession should feel deeply indebted to him for such a valuable piece of literature.

Records have been traced back to the early days of medicine where diseases of the nose and throat are mentioned as having occupied the attention of the medical men of that day and time. The progress of medicine in that special line has been traced upward through the ages from the day when fetiches and an assumption of a knowledge of magic constituted the physician's entire stock in trade, to the present day of scientific treatment of disease based upon a knowledge of the etiology and pathology of disease, and of the anatomy and physiology of the human body. Besides containing a fund of valuable information, the book is as entertaining as a novel and should be read by every student of laryngology.

DEROALDES & KING.

Year Book of the Eye, Ear, Nose and Throat, Vol. III. HEAD, ANDREWS, WOOD & HARDIE, Editors. The Year-Book, Publishers, Chicago.

This work is the third volume of the series of year books sent out by these publishers covering the entire field of medicine and surgery. The object of the book is to keep before the profession the latest advances and improvements in all the branches, and its compilation reflects credit on the spirit of progression and modernism that inspires its editors. This volume devoted to the eye ear, nose and throat could with advantage be more extensive in its treatment of various subjects, but in spite of its brevity covers the ground pretty thoroughly and is well worthy of perusal. DEROALDES & KING.

Publications Received.

W. B. Saunders & Co., Philadelphia and London, 1905.
Addresses and Other Papers, by Dr. William Williams Keen.

Lea Bros. & Co., Philadelphia and New York, 1905.
Progressive Medicine. Vol. VII. Hare-Landis.
A Practical Treatise on Fractures and Dislocations, by Dr. Lewis A. Stimson. 4th edition.

J. B. Lippincott, Philadelphia and London, 1905.
Psychiatry, by Dr. Stewart Patton.

Miscellaneous:

Transactions of the American Pediatric Society. 16th session. Edited by Dr. L. E. La Fetra. Vol. XVI.

Kentucky Agricultural Experimental Station of the State College of Kentucky, Bulletin No. 119.

Mouth-Breathing, by Dr. W. H. Fitzgerald.

Bulletin of Storrs Agricultural Experimental Station, November, 1904,

Address of A. A. Cortelyou, President, at the Annual Meeting of the Holstein-Friesian Association of America, Syracuse, N. Y., June 7, 1905.

Reprints.

The Universal Method of Clinical Writing by Means of Clinography, by Prof. V. Pensuti.

A Manual of Acute Poisoning, by Dr. John W. Wainwright.

First Aid to the Injured, by Dr. J. W. Wainwright.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR JUNE, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	8	3	11
Intermittent Fever (Malarial Cachexia)	4	1	5
Small Pox	......	......	......
Measles	......	......	......
Scarlet Fever	......	......	......
Whooping Cough	5	1	6
Diphtheria and Croup	2	......	2
Influenza	......	1	1
Cholera Nostras	......	......	......
Pyemia and Septicemia	1	......	1
Tuberculosis	45	41	86
Cancer	18	4	22
Rheumatism and Gout	1	......	1
Diabetes	1	......	1
Alcoholism	1	1	2
Encephalitis and Meningitis	12	4	16
Locomotor Ataxia	......	......	......
Congestion, Hemorrhage and Softening of Brain	16	3	19
Paralysis	1	2	3
Convulsions of Infants	5	3	8
Other Diseases of Infancy	23	15	38
Tetanus	3	1	4
Other Nervous Diseases	2	......	2
Heart Diseases	30	21	51
Bronchitis	2	4	6
Pneumonia and Broncho-Pneumonia	18	8	26
Other Respiratory Diseases	1	3	4
Ulcer of Stomach	......	......	......
Other Diseases of the Stomach	3	2	5
Diarrhea, Dysentery and Enteritis	80	31	111
Hernia, Intestinal Obstruction	2	2	4
Cirrhosis of Liver	1	6	7
Other Diseases of the Liver	4	3	7
Simple Peritonitis	2	1	3
Appendicitis	3	1	4
Bright's Disease	33	15	48
Other Genito-Urinary Diseases	5	2	7
Puerperal Diseases	6	4	10
Senile Debility	17	6	23
Suicide	2	......	2
Injuries	21	9	30
All Other Causes	14	15	28
TOTAL	392	213	605

Still-born Children—White, 17; colored, 24; total, 41.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 19.68; colored, 29.72; total, 22.33.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**29.96**
Mean temperature	**82.**
Total precipitation	**7.55 inches.**

Prevailing direction of wind, southwest.

New Orleans Medical and Surgical Journal.

VOL. LVIII. SEPTEMBER, 1905. No. 3

Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

Some Yellow Fever Data.

By PROF. STANFORD E. CHAILLÉ, A. M., M. D., LL. D., New Orleans.

The results of the present warfare on mosquitos will be of vital importance to New Orleans, and of profound interest to sanitarians throughout the world. It should be understood that this city faces three serious obstacles to stamping out the disease promptly, viz: delay in inaugurating preventive measures, the greater number than ever before of non-immunes, and the number of deaths (62) as early as July.

To stamp out the disease under these and other unfavorable conditions would be an astounding triumph, to greatly diminish its prevalence and mortality, and to hasten the date when non-immunes may safely return would be of inestimable value to New Orleans and its future.

It is greatly to be feared that the public may become discouraged by the continued occurrence of some cases and by its inability to estimate the good results that it is confidently believed will ensue from the preventive measures now being executed. The following table has been compiled to present some of the most important facts requisite to correct conclusions.

Table of *all* years in the history of New Orleans when the *officially reported* deaths by yellow fever in July are fairly comparable with said deaths in July, 1905—in order to indicate the influence of the present warfare on mosquitos, and the time, heretofore, when the disease disappeared. The data of 1867 and 1878 are worthiest of consideration.

	1847	1848*	1853	1854*	1855*	1858	1867	1878	1905
May			2						
June		4	31	2	5	2	3		
July	74	33	1521	29	382	132	11	26	62
August	965	200	5133	532	1286	1140	255	1025	?
September	1000	467	982	1234	874	2204	1637	1780	?
October	198	126	147	490	97	1137	1072	1065	?
November	12	20	28	131	19	224	103	147	?
December	10		4	7	7	15	26	3	?
Months Unknown	445	22							
TOTAL	2804	872	7848	2425	2670	4854	3107	4046	

* The epidemics of 1848, 1854, 1855 are least comparable for 1905, because they immediately succeeded severe epidemics to which were due very many immunes.

N. B. Population of New Orleans by U. S. Census: 130,565 in 1850; 168,675 in 1860; 191,418 in 1870; 216,090 in 1880 and 287,104 in 1900.

Micro-Biologic Researches in Syphilis.*

(By Drs. H. METCHNIKOFF and EM. ROUX.)

Communication to the Academy of Medicine (Paris), May 16, 1905.

(Translated for the Journal by Dr. H. E. Ménage, Chief of Clinic to the Chair of Diseases of the Skin, New Orleans Polyclinic, New Orleans.)

In the course of our studies on experimental syphilis, we were led to examine syphilitic products microscopically. A great deal of work, for a long period of time, had been done to discover the etiologic cause of syphilis, but with either negative results or very incorrect conclusions.

**Revue pratiq. des. malad. cutan., syphil. et vener.,* June 1905.

During the early part of this year a German zoologist, Siegel, published an article on the subject which created quite an impression, particularly in Germany. He described in the blood and exudates from syphilitic individuals a very small protozoon which he stained with a mixture of anilines—azur and eosin—and which he held responsible for the production of syphilis. Although the microphotographs and description given by Siegel left little doubt as to the basis of this opinion, scientists began to examine the question by a new series of experiments. So Mr. Schaudinn, an authority on the subject of protozoa, was placed in charge of the Berlin Sanitary Bureau (Kaiserliches Gesundheitsamt) to conduct experiments in order to verify the above conclusions. His first examination was of a mixture from the secretion of the chancre with azur and eosin, in which he found a number of spirilla feebly stained and with special characteristics. Schaudinn, who has had an extensive experience with the spirillum, at once understood the importance of his discovery and began a systematic study of these microbes with the assistance of Hoffman, who had charge of the medical side of the question.

For a long time already, the spirillum had been found in lesions of the genital organs and even upon the mucous membranes of normal ones. But it is only from an historical standpoint that we mention Druné's opinion, 1837, that the spirillum should be considered as the true cause of syphilis. In fact, it was impossible for Druné, with the means at his command at that time, to have seen spirilla so minute as those discovered by Schaudinn.

But many observers have found spirilla on the genital mucous membrane. I will mention only two instances of Alvarez and Tauel, who found spirilla in smegma, and of Berdal and Bataille, who found the same micro-organisms in the secretion of cases of ulcerative balano-posthitis. During the past few years Rona, of Budapest, did considerable work on the subject of the spirillum which he recovered from gangrenous ulcerations of the genital organs. Among numerous other observations this author mentions the presence of a spirillum in nine cases of primary lesions in man, but they do not occur to him as the cause of syhpilis, as he finds the same spirillum in non-syphilitic lesions and the smegma of the genitals in both sexes. It becomes, therefore, a question as to whether or not the spirillum discovered by Schaudinn in primary lesions is not identical with those found by his predecessors. In the beginning of his work, Schaudinn himself asks the question; but his intimate knowledge of the spirillum also suggests to him the possibility of two varieties which he classifies with the class spirochœtæ; one which is found in papillomata of the genitals, in balano-posthitis; also in syphilitic products and even in normal smegma and another which could exist only in syphilis.

In his first paper published with Hoffman, Schaudinn does not express himself positively, but in his second he insists upon two types of genital spirochœtæ; one he calls the spirillum *refringens*, and the other spirillum *pallida*. The first is characterized by its relatively large size, by the form, which resembles naves, and the ease with which it is stained with ordinary coloring substances. The spirillum pallida is differentiated by its small size, by its corkscrew appearance and by the difficulty with which it takes ordinary stains, necessitating the special staining mixture of azur and eosin of Giemsa.

It is possible that some of the above-named observers may have seen this second variety of spirillum; they have, however, not recognized its specific identity, and their descriptions leave scarcely any doubt that they had to deal with the spirillum refringens. In fact, all of them mention the ease in staining the micro-organism, and its size. Rona gives a diagram of these spirilla, found in a case of ulcerating mercurial stomatitis (*L.c.* Tab-x, fig. 4) which suffices to establish its identity with the spirillum refringens of Schaudinn.

We know of but one instance where the spirillum pallida was seen before it was recognized by Schaudinn; it was an unreported observation. It will be three years since Mr. Bordet and Gengou have been searching for the microbe of syphilis with a perfected technic. With that aim they stained the syphilitic products with carbolated gentian violet of Nicolle. In that way they found in a chancre a fairly large number of fine spirilla, lightly stained and corkscrew in shape, and more, the spirillum were uncontaminated with other microbes. Messrs. Bordet and Gengou naturally became enthused over that observation, and began looking for their spirillum in other cases of syphilis. But failing to find the microbe in five cases, either in the primary lesions, in the inguinal lymphatic enlargement, the blood and in the papules of an eruption, they became discouraged and stopped further researches. It was only in a mucous patch of the throat that they found the same spirillum; but since in the throat, even normally, almost similar spirilla are found, they did not attach any importance to their finding. A few days ago Mr. Bordet sent us one of his old preparations on which was recognized without trouble a spirillum identical with the spirochœta pallida. After obtaining our first results with syphilis in chimpanzees, Mr. Bordet related to us his experiments, which suggested our search for the spirillum in these animals. Aware of the great difficulties we should encounter in our experiments, we examined only the contents of the small herpetiform vesicles which occasionally appear in early syphilis. In this fluid we thought the micro-organisms would be found in great numbers, and could be seen active in the condition that they are found in the blood of cases of recurrent fever.

The result was negative, and we could not detect the slightest movement in the mass of floating microscopic particles. The addition of neutral red, which ordinarily makes observations of other spirilla so easy, proved negative; in the same manner preparations stained by different methods failed to reveal spirilla.

These negative results did not permit us to accept the spirillum as the specific cause of syphilis, as we have stated in our third memoir of the *Annales de l'Institut Pasteur.* It was the splendid investigation begun by Mr. Schaudinn which led us to examine again the syphilitic products from monkeys, and which caused the change in our opinion. After having found in his first case of syphilis a great number of spirochœtæ pallida, colored by Giemsa's mixture, Schaudinn studied other cases, and although in his second case (mucous patches of the labia majora) he found but very few spirilla, in another similar case, examined the next day, he determined the presence of numerous pale spirilla. Up to the present time Schaudinn and his collaborators, Hoffman, Gonder and Neufeld, have studied 26 cases of primary lesions and mucous patches of the genital organs (from Mr. Schaudinn's last letter) and have always found the pale spirochœtæ, although in some instances in very small numbers. Often they are so thin and pale that it takes a long time to find them. Sometimes it is necessary to go over four slides before finding one solitary spirochœte. The presence of this microbe was detected not only in the secretion of syphilitic lesions of the genitals, but also in the deeper tissue of chancres and mucous patches, as well as in eight syphilitic inguinal buboes, during the primary and secondary manifestations. Siegel, although his *cytorhyctes luis* lacks confirmation, does not hesitate to proclaim it as the etiologic cause of syphilis; Schaudinn and Hoffmann, notwithstanding the great importance of their discovery, are very reserved in their conclusions. They end their last note with the following: "Although we have succeeded in finding regularly, in eight well studied cases, in the secretion of syphilitic buboes the pale spirochœte, which appears to differ from all other known species, we are none the less far, at this moment, from expressing a positive opinion upon its etiologic role.

"In the same manner, in our first report we rest satisfied to only note our observations and allow to future researches the solution of this most important question."

Not having any monkeys at his disposal, and believing that microscopic researches practiced on monkeys would hasten a solution of the question, Mr. Schaudinn sent us some of his preparations, and gave us the details of his method before his first report, for both of which we thank him very much.

Notwithstanding the great importance of the facts brought out by Schaudinn and his collaborators, it is a question whether the etiologic function of the pale spirillum was sufficiently determined, since their presence is so uncertain in syphilitic lesions of the mucous membranes which are so accessible to all sorts of microbes. Even the presence of these spirochœtæ in the deeper strata of syphilitic lesions of the genitals, as well as inguinal buboes, could not carry conviction. It is, in fact, natural that microbes so mobile should migrate beyond the point of their first appearance. It is well to remember that the bacillus of Lustgarten also was found in the depth of syphilitic tissues, and still no one attaches any importance to it as an etiologic, syphilitic factor.

The impossibility of finding his pale spirochœte in the blood of syphilitic individuals as well as in the smears from two primary lesions in monkeys (baboons) sent him by Mr. M. Kraus (Vienna) made Mr. Schaudinn hesitate and increased his desire to obtain, as soon as possible, full information on the subject of anthropoid apes.

Mr. Schaudinn placed Mr. Kraus in touch with his researches, and requested him to supply us with some of the preparations. It is through Mr. Kraus that we learned of the discovery of the spirochœte in syphilis; we begged the able bacteriologist from Vienna to help us in our first experiments. We studied first the smears obtained from chancres in two chimpanzees, one under treatment with a serum and almost cured, while the other had a chancre of the penis of 46 days' duration, that is, fully developed. Although we used the method of staining prescribed by Schaudinn, we failed to find spirilla as Schaudinn did previously in preparations from baboons sent him by Kraus. The first positive result was obtained by us in a *macacus cynomolgus* which had a primary lesion over the supra-orbital region. This lesion, which was covered over with a thick crust, exuded a pinkish serum-like secretion, in which we found, 25 days after the incipiency of the lesion, quite a number of spirilla. On the other hand, in a subject of the same species, inoculated in the same manner and with the same virus, we could not find any spirillum. This fact, added to so many others, goes to show the great variability in the number of spirochœtæ to be found in syphilitic lesions. It became, therefore, very necessary to observe the condition of affairs from the appearance of the primary lesion.

Among our many monkeys, anthropological and otherwise, inoculated with syphilitic virus, there was a baboon which showed, after the 25th day of inoculation over the supra-orbital ridge, a small oval spot (macule) hardly to be differentiated from the healthy, surrounding tissue. It was only two days after that the spot assumed the character of a primary lesion; surrounded by a reddish brown zone, it was covered in the center by a thin crust In the smear from this very recent lesion, we found very characteristic and quite a number of pale spirochœtæ. Whereas, numerous microbes were found in one of the five smears made from the same material, in the four others we could not find a single one, showing how capricious is the distribution of the spirilla in syphilitic products. We again examined the exudate from a very recent primary lesion in a "papion" (*cynocephalus sphynx*), and although we had become fairly skilled in the search for the pale spirillum, we found only rare examples on the 4th slide, which was most carefully examined. After the findings, of which we have just given a synopsis, we again began a search for the spirochœtæ in the syphilitic products obtained from our two chimpanzees above mentioned. This time we found, after most laborious searches, extremely few spirochœtæ on smears made from the chimpanzees suffering from a chancre of the penis. In all, with six monkeys with which we experimented, we determined the presence of spirilla in 4 cases; in a chimpanzee, a paprion, and two baboons. One of the chimpanzees was so nearly well that the absence of the microbe, or our failure to find it, is not astonishing, so there remains but one baboon which gave us negative results, and which, in view of the unequal and capricious distribution of the spirillum of the small number of examinations we could make, our negative result can, in a way, be explained. Our 4 positive results were obtained from the chancre on the penis of a chimpanzee and 3 primary lesions on the skin (and not mucous membrane) of the supra-orbital regions of the paprion and two baboons. The appearance of the pale spirochoete is quite characteristic, and therefore easily differentiated from the spirillum of mucous membranes.

Futhermore, it is impossible to deny the syphilitic nature of the lesions on the baboons and paprions. Even Mr. Messer, after having denied for a long time the possibility of primary accidents in inferior types of monkeys, concurred in our opinion in a paper recently published. On the one hand, the great resemblance existing between the experimental lesions in monkeys and those of syphilis in man can not be contested; on the other, the identity of the spirilla found in both cases is certain.

Mr. Schaudinn, to whom we sent one of our preparations containing the spirochoetae from a baboon, also identified it.

Experimental syphilitic lesions produced in monkeys, on sites other than the mucous membrane of the genital organs, furnish a strong argument in favor of the etiological responsibility of spirochœtæ in the disease.

After being in possession of the above facts, we began looking for the pale spirochœtæ in the scrapings from a papular syphilide on the skin of man, and located at a distance from the initial lesion of the genitals. Of six cases examined to date, 4 gave positive results. Sometimes the spirochœtæ were numerous and existed without other microbes. The fact that the spirochœte was found by us in early papules, those not showing crusts or even scaly borders under the magnifying glass, indicates that those microbes were not the result of accidental contamination from the outside, but were carried there through the blood or lymphatic circulation.

Although we have been able to demonstrate the presence of the pale spirillum in 8 cases of syphilis (4 monkeys and 4 men), with out counting the few cases of microbes found in chancres of the penis, we have not been able to see them alive, which would have a tendency to prove that the number of spirochœtæ must have been very small. Our method of staining was that of Giemsa for 16 to 20 hours. To obtain results in less time we used Marino's method, which consists of a mixture of azur blue in methyl alcohol and a mild aqueous solution of eosin. This method does not stain the spirochœte as well as Giemsa's but has the advantage of taking much less time, and occasionally we made a positive diagnosis in 15 minutes.

Notwithstanding the great scarcity of spirochœtæ pallida found in many cases of syphilis, we believe the search for their presence useful from a diagnostic standpoint.

Therefore we rely upon this method to differentiate secondary syphilis as in the chimpanzee from a variety of other skin lesions resembling syphilis to which they are prone. We are supported in our theory by the fact that it was impossible for us to find these spirochœtæ in any non-syphilitic cutaneous disease in man, such as psoriasis, scabies and acne.

It would be very important to obtain outlines of this spirochœta pallida, but the great difficulty confronting us in making cultures of spirochœtæ similar to those of syphilis, and which are found in abundance, such as in relapsing fever, and the spirillum disease of birds, make us fear that the solution to the problem is still very remote. Whilst waiting for cultures we shall continue to use the virus products of the lymphatic glands and the secretion from primary and secondary lesions to prepare our anti-syphilitic serum. Before arriving at a definite conclusion concerning the etiologic importance of the spirochœta pallida in syphilis, and in the absence of pure cultures of that microbe, it will be necessary to continue experimenting and gather a great number of facts, but a synopsis of all we have said pleads strongly in favor of the theory that syphilis is a chronic spirillum disease caused by the spirochœta pallida of Schaudinn.

European Notes—Vienna.

By Dr. I. I. Lemann, New Orleans.

After a sojourn of some two months in Vienna I feel I may venture a judgment of the medical conditions here. What I am about to write has, of course, been seen from the standpoint of the average American medical man who has come to study German methods of diagnosis, of treatment, and of clinical teaching, and I hope therefore it will be of interest to the average stay-at-home from the point of view of comparison, as well as to those who may entertain ideas of coming over here for a *"Fortbildungskurs."*

At the outset let it be said that the Americans have, practically by their demand for instruction, created a supply of special post-graduate courses more or less adequately suited to their needs. In other words, there has come to exist a post-graduate school in a somewhat loose relation to the university—a school in which the Americans are almost exclusively the students, and in which the instruction is given by the first assistants of the great clinicians or by some of the younger professors. Some of the courses are regular university courses, and one has to matriculate in order to participate in them, but the great majority are not regular courses though the instructors are all university docents or professors. It is the general rule that the number of students in each course is limited to ten, a few have only five and one or two have as many as twenty. Many of these "Amerikaner" courses have been turned over by the instructors to the American Physicians' Club for their management; that is to say, the club controls the courses and makes rules for them. In order to gain admission to these courses one has to apply therefore to the Americans. The chief rule is that of precedence. By this is meant that age in point of residence gives the advantage; one registers at the Club upon his arrival in Vienna, and only after he has attained to a certain position in the waiting list by older men leaving does he get into the very popular and sought after courses. After registering one may go to Berlin, to Strassburg, Paris, or wherever he pleases in Europe without losing his place; only he must not return to America and must not remain two semesters away from Vienna. *From this it is clear that for any one coming abroad for a protracted stay, and having even the slightest idea of studying in Vienna, it is an advantage to come here first, register and then if he pleases go elsewhere to do his first work.*

Nominally the courses run a month and begin again, and this has given the idea to some observers that the courses are supposed by the Americans taking them to be complete, "finished" instruction in each subject in each month. This is really doing the courses and the average American an injustice. Men remain month after month in the same courses, for as we shall see, the "course" simply amounts to the privilege of intelligently using the enormous material here plus the instruction and comment of men who study their cases carefully and are on their mettle each day to exhaust the specific subject under consideration. The corps of instructors in this American school shift somewhat from time to time, for if the men find any instructor unsatisfactory, he is relegated in favor of another in some other clinic. It is needless to say that there are a number of parallel courses running; that is apparent from the statement that only ten men are in a course.

So much for the general outline of this post-graduate school. Of what value are these courses, and to whom are they valuable? In the first place let it be said that their value lies in three points, namely: (a) The abundance of material; (b) the small number of participants in a course and the consequent contact of the student with the patient; (c) the careful preparation of the case demonstrated and the conscientious comparison of post-mortem findings with clinical diagnosis. This training is first of all valuable to those who have had no hospital experience; secondly, to those who have had hospital work, but to whom it suggests new lines of thought and particularly a careful reasoning out of each clinical problem presented, and lastly to those who are interested in the study of the best methods to teach medicine.

The most popular teacher here is Kovacs in internal medicine. His course is always full months ahead. Kovacs is a man of about forty and has only a short time ago attained to his extraordinary professorship. It was told by an Austrian student that Kovacs' record as a diagnostician ranks next to that of Neusser. It seems a record is kept by the pathological department of the percentage of clinical diagnoses in each service verified (or the contrary) at autopsy. While making use of all the modern scientific clinical laboratory aids to diagnosis Kovacs does his students good service by carrying his physical examination methods to the extreme point of thoroughness before turning to the laboratory for assistance. The common comment is that he should have been a lawyer; that he argues out the probabilities in a case as he would a case at law.

But let it not be understood that attending these "Amerikaner" courses is all that a man may do here in Vienna. There are, first of all, the clinics to attend; Neusser and Nothnagel in medicine; Schauta, Chrobak, in gynecology; Politzer in ear; Eiselberg and Hockenegy in surgery, etc. In medicine most Americans attend Neusser's clinic. Few Austrian under-graduate students go there because Neusser's talks are over their heads; in order to appreciate them one must have had some experience. Recently he has been lecturing on angina pectoris, a subject into which he goes exhaustively. He talks with bowed head and a very low tone of voice, rarely looking at his audience, so that it is difficult to hear what he says.

Then there are the laboratories—pathology, chemistry, physiology, physiological chemistry, etc., where one can devote his whole time if he chooses to the working out of a selected problem or spend his time in perfecting his knowledge along the beaten paths. In other words, there is plenty of opportunity for work here.

Comparing the condition here with the atmosphere and the opportunity afforded in a smaller university town I think I may sum up the chief difference as it strikes me as follows: Here the material is more abundant and the conditions for *post-graduate* instruction better, while in the smaller university one can, I believe, do original work better, come closer into contact with the chiefs and be correspondingly stimulated in his work.

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P. L. Thibaut, M. D. Chairman.

Success In Medicine.

By L. LAZARO, M. D., Washington, La.

It is a well known fact to the medical profession that only a small number of its members succeed. This, to me, seems to be a serious problem, and one which demands consideration. Ours is an exalted profession, and we should, one and all, endeavor to succeed.

Some will tell us that the medical profession is over-crowded, but gentlemen, you will agree with me when I say that there is room anywhere in this country for a good, level-headed, all-round physician.

Of course there are different opinions as to what constitutes success. I think the successful physician is a man of good moral character, who keeps himself well posted, and gives to his patient the very latest and best in conservative therapeutics, who is just and kind to his neighbor and brother practitioner, and at the same time provides enough to have his family respectably housed, and decently clothed, his children well educated for the duties of life, and a fair provision made against sickness and old age. There are others who will tell us that a poor boy has no chance. This we know is not so; look at the life of that eminent and good man, Prof. Metz. It gives a true story of genuine success from real life, a practical illustration of what a man can make of himself by perseverance, by self-confidence, and by keeping before himself high ideas, and he has showed what opportunities are offered to all men in this great free America, and to what high positions men can rise if they make the best of advantages which are held out to them at some time in their lives—a poor boy without help, who, by struggle through hardships, made of himself a student and scholar, and who today is one of the ablest scientists of the United States, and who occupies the chair of Chemistry in the Tulane Medical College. I appreciate the difficulty of telling a young man exactly what he should do, but I believe that if we appeal to his judgment and endeavor to show him the road, we will have done our duty. So let us now buckle on our armor of determination and become valued members in our profession.

First, let us select a good location; if possible it is better to locate where one expects to stay; let us be enthusiastic in our work, and never stop for obstacles; let us cultivate the staying at home habit, so we can answer all our calls; let us be full of sympathy for our suffering patient, and poor, anxious parents, for we must remember at this critical time they are not themselves, and are generally a source of great worry to the family physician, but let us not, under any circumstances, speak rudely. The "old woman" will suggest different lines of treatment; treat them politely and never make light of them, as they will often observe things we have overlooked. "Every cloud has a silver lining," and when the sky clears we will reap our reward. Let us examine our patient thoroughly from head to feet, never fall into the habit of making "snap shot" diagnosis and routine treatment. Our idea of a charge should be not for a call, but for service rendered, and if possible, let it represent relief given or life saved. Always guard your prognosis, because we will often be surprised at the result. There is a class of nervous people that we must be very careful in dealing with. I mean, of course, those patients who imagine they are ill when they are not; or those who magnify the slightest trouble. Let us be serious and kind, and do all we can to make them feel satisfied, because if we are rough with them they will invariably leave our office angry, and often fall into the hands of the quack to be ruined. It is here that a placebo and a little suggestive therapeutics will do good. Another point of importance is to have confidence in ourselves, and others will confide in us. Our education at college has been practical, we had the guarding Professor at our elbow, the responsibility rested on others. All this changes when we enter our field of practice. We are to go alone, relying upon our own judgment and common sense in the responsible duties of our life's work. We must make friends, gain the confidence of the people, and when they give us an opportunity, do as Watterson said, put the "round peg in the round hole, and the square peg in the square hole." Remember the temptation for gambling and drinking, and avoid it. Nothing can ruin a physician quicker. Without self-control there can be no success.

We may imagine during the first year or two in which practice comes slowly, that there is no hope, and that we must change location. Don't do it, and remember that these are the precious years of our preparation for future struggles. This brings us to the importance of studying systematically. Every day devote as much time as we can to the careful study of the best authorities, and remember if we are not a better doctor today than we were yesterday, we are a poorer one.

Medical science is marching rapidly, and we cannot stand still. To study is not all. We must apply what we know. In other words, we must learn to be practical at the bedside. At the end of every year, let us carefully review our work, and in it we will find many useful lessons, warnings against mistakes made, and encouragement from success achieved, and the necessity for wider study and closer observation. Let us try to cultivate the friendship of our fellow-practitioners so we can compare views; this is necessary to the complete education of the true physician, and if for no other reason, let us do it for the good of the patient. In consultation, think of the patient, never criticise the other fellow; he will probably do the same thing, and both will be lowered in the estimation of the people.

Join the medical societies, and attend the meetings. We will always learn something, and at the same time it means recreation.

Occasionally look up our notes, and write a short, practical article for some medical journal; it will train our thoughts. Now, I do not mean that we must work all of the time, and never take a day for rest and pleasure. Some think that because it is our business to deal with the sick, that we should be sad all of the time. It is not a rare thing to hear soldiers sing between two battles, and I think myself that human joy has celebrated its finest triumphs under the greatest test of endurance. There are a few dangers that appear to me just now, and I wish to call your attention to a few of them.

First, politics. Let us be careful, especially if we are a beginner, to perform our duties of citizenship without taking an active part. Second, religion. It is a good and safe rule to respect every man's belief. Third, family feuds. No matter how intimate we may be with one side, let us always keep our mouth closed. Respect the opinions of those who know less than we do. Never criticise quacks and midwives; they will raise the cry of persecution; but educate our clients, and things will come our way. As Bacon says, "Truth is the daughter of time."

Let us now review what we have gone over—we are well located, we have friends, we have given relief, we have cured disease, and saved life, now it becomes our duty to see that we are well compensated. This brings us to the business side of our profession. We all know that when a patient calls us he wants us to be in good humor, wants us to get to his home right away, wants a quick and correct diagnosis, and wants good medicine; if there is any cutting to be done, he wants the instruments to shine and cut well.

This is the time to teach that to be in good humor one must sleep comfortably in a good house, have a full stomach and good clothes; to travel fast, must have a good buggy and first-class horse; to make a quick and correct diagnosis must have the best books; to give medicine, must be able to buy the purest drugs, and they must be carried in a well-closed case; and to be prepared to cut, must have a good and complete surgical outfit. And these things cost money. I believe we should charge a reasonable fee, and attend to our collections.

Never forget to charge our work, keep our books well posted to date, so that we can settle at any time. Even if a man cannot pay us at all, compel him to look over the book so he will know exactly how he stands.

If a person leaves the community without paying, always take his note. To be a good collector, one must study character somewhat. Not all must be approached alike—some with quiet reserve, others with a smile and a cordial handshake, and others with a hard luck story, and some in a very firm manner. Our patients may for the sake of description be divided into four classes.

1st. Those who take the trouble to find the doctor, and worry themselves until he is paid. Never ask these for a settlement unless you are really in need.

2nd. Those who are indifferent regarding the doctor's bill until it is presented, but who will then pay. Be careful with this class, do not let the bills grow.

3rd. Those who never pay unless caught in the very act of beating you, and this is the class which flocks to the beginner. When they are sick, their gratitude is a very prominent symptom, but it declines rapidly during convalescence, and disappears entirely upon recovery.

> "The Doctor like an angel seems,
> When he in the sick room brightly beams,
> And like unto a god is he,
> When he removes the malady,
> But in a different light we view
> The Doctor when his bill is due,
> Our lifted eyes we at him level,
> As if he were the very devil."

But, gentlemen, there is one thing I would like to remind you of about this class we call professional deadbeats; if we can't succeed in making them pay, they will never cease backbiting us in order to justify themselves. We should accept anything we can get from them, and never do any work for them unless we are protected, and then they will at least respect us.

4th. Our charity patient. Let us do all in our power to relieve these poor unfortunates. If we are able, it is our duty, not only to give our services and medicine, but assist financially, but we must be very careful in drawing the line between the "deadbeat" and the poor man or woman who cannot pay. Charity is the sweetest morsel that one can taste, and its flavor is delicious when given to the unfortunate and needy.

The Early Diagnosis of Carcinoma of the Stomach.

SIDNEY K. SIMON, A. B. M. D., New Orleans.

Carcinoma of the stomach, because of the high and ever-increasing frequency of its occurrence, with a prognosis acknowledged to be the gloomiest of the gloomy, is a subject well deserving of the highest consideration of the profession. As a leading member of the great group of malignant diseases, it might even lay claim to a place along with tuberculosis and pneumonia, as one of a triad of the more pressing medical problems of the day whose solution still awaits our best efforts and highest thought.

While in point of frequency, it is true, carcinoma of the uterus would seem to deserve the higher prominence, still the problems it presents are, broadly speaking, no longer fraught with the same perplexing difficulties as is still the case with carcinoma of the stomach. From its very location, which allows of more direct approach to our diagnostic methods, the uterine carcinoma is far more accessible to an early diagnosis, and therefore more amenable to radical treatment, than is the deeply hidden gastric form. It is primarily because of the graver difficulties which thus seem to beset its early diagnosis that carcinoma of the stomach becomes of so much larger and more serious moment to the profession. For, at least with all our internally situated malignant diseases, it is the early diagnosis and that alone which forms the real essential element in the problem they present for treatment, and therefore whatever means we may succeed in adding to our armamentarium for lessening the difficulties of their early diagnosis represents but a step of like degree towards robbing them of their terrors. It is no great matter how proficient our operative technic may be if, despite its uniformly high proficiency, the ability to establish an early diagnosis still fails us.

The successful treatment of carcinoma of the stomach, as with all malignant conditions, thus may be said to depend upon the radical excision of the entire malignant area, which is, however, only possible when the diagnosis has been made sufficiently early. When once the disease has passed beyond the power of the knife, the die has been cast and we all know then what a hapless picture of hopelessness and distress we are called upon to face.

With a full realization of this I have, therefore, chosen the early diagnosis as my theme, and will attempt to pass in review briefly the full sum of our knowledge on the subject.

First of all, however, a word as to a clearer understanding of the term, early diagnosis, would seem in place. From the very nature of things, the term being but a relative one, no hard and fast line can be drawn in the definition. More often than otherwise it is, after all, to the surgeon that we must turn for the decision whether the diagnosis has been made sufficiently early or not; still, in a broad clinical way, it is safe to say that when once a tumor becomes palpable externally the chances for a radical cure have become extremely meager. This should, however, by no means be taken as an absolute rule. The thinness and laxity of the abdominal walls have much to do with the feeling of a tumor, and again we have numerous cases in which throughout the entire course of the disease no tumor can be felt. It would, therefore, be perhaps better to say that the real boundary line between the early and late diagnosis depends upon the extent with which the growth has invaded the surrounding parts. The internist, ever working in the dark, must content himself with the making of the diagnosis just as early as possible, and then let the surgeon finally decide whether it has been made sufficiently early or not.

In approaching now our problem of establishing the diagnosis just as early as possible, we may, for purposes of convenience, divide the disease in three great clinical groups, each presenting a somewhat different picture and clinical course.

1. The pyloric carcinoma, leading to stenosis at the pyloric end of the stomach.
2. The interosseal carcinoma, involving the stomach wall either on the anterior or posterior aspect, but without causing obstruction at either orifice.
3. The cardiac carcinoma, resulting in obstruction at the cardiac orifice.

This, it must be understood, is a convenient, but purely arbitrary division without a true pathological basis in the strict sense of the term. As a matter of fact, we know now from the overwhelming statistics of the dead house that by far the greater number of carcinomatous growths of the stomach have their origin at the smaller curvature, from where they may spread out secondarily, and most often do, in three possible directions, which would coincide with the clinical division as given above.

This, while the usual rule, is, however, by no means an invariable one. The tumor may take its starting point from any part of the stomach, as, for instance, on the basis of an old ulcer scar, and show little tendency to invade other portions of the wall. From the clinical standpoint this is more or less irrelevant. The important point is not so much where the growth may have happened to start from, as it is to recognize it when it first becomes in a position to give evidence of its presence.

Practically by far the most frequent site, whether primary or secondary, is the pylorus, and it is fortunate that it is so, in the sense that it is the form which allows of the earliest and surest recognition. As the tumor gradually invades the pylorus, all the while narrowing its ring, it tends more and more to block the exit of food from the stomach to the duodenum. This can have but one result, a stagnation of the chyme, which Nature feebly attempts to overcome by an hypertrophy of the stomach wall. A dilatation, with its hosts of attending evils and symptoms, is the inevitable result. It is this stagnation of the food, this lingering when the stomach has normally finished with its chymification, that offers us the best evidence and often the first suspicion that a tumor is invading the pylorus.

The discovery of such a pyloric stenosis, even when not far advanced, does not offer the greatest difficulty. The normal stomach, after a moderate midday meal, represented conveniently by the Leube test meal, should empty itself in seven, or at most eight, hours. If after that time we syphon off the stomach and find remnants of food particles still remaining, we might conclude, with reasonable certainty, that there is some mechanical obstruction to the exit of the food into the duodenum. The so-called atony of the stomach, about which so much appears in our text-books, in the light of newer investigation, is rarely a pure muscular insufficiency, but nearly always a condition of dilatation following pyloric stenosis.

If, however, some lingering doubt remains of the reliability of this test, the washing out of the empty stomach after a night of fast will furnish conclusive proof of the existence of stenosis. In the morning, under normal conditions, the stomach should contain not more than 15*c. c.* of pure gastric juice. If, in addition, there be a single food particle from the evening before, nay more, even a microscopical particle, there is positive evidence of an obstruction at the pylorus.

With this determined it is scarcely necessary to say, however, that the diagnosis of pyloric carcinoma is by no means made. We have a whole series of other conditions favoring obstruction at the pylorus, and the next differential point must be the exclusion of each and every one of them. It is here that the careful chemical and microscopical examination of the stomach contents lends us valuable aid.

Is our pyloric stenosis associated with an excess or diminution of HCl becomes an important, and, indeed, as we shall see, the real pivotal question in the differentiation. We might simplify the problem conveniently by a subdivision such as:

1. Conditions in which pyloric obstruction is present associated with an excess of HCl.

2. Conditions in which pyloric obstruction is present with a diminution or absence of HCl.

Under the head of No. 1, that is stenosis with excess of HCl, we might say fall all our benign strictures, such as secondary spasm of the pylorus, as a result of erosions, fissures or ulcers on the pars pylorus, old ulcer scars with a permanent narrowing of the orifice, benign tumors or tumefactions of any kind, either on the inner or outer aspect of the pyloric ring. These processes are nearly always accompanied by an excess of acid, or perhaps it were better to say never with its absence or progressive diminution, as is the case with malignant stenosis.

In the presence of stagnation, either of benign or malignant origin, the stomach offers a fertile field for micro-organisms of many kinds, and the presence or absence of HCl becomes the determining factor in the varieties which we find. In the presence of an inorganic acid, the sarcinæ and yeast cells seem to find a specially favorable medium for their development, and thus it is in benign stenosis that the microscopic field contains large numbers of sarcina boles and yeast cells in chains. On the other hand, when HCl is absent, we find, among others, the long branched Oppler-Boas bacillus, which suggests at once malignancy.

There is only one malignant process associated with pyloric obstruction in which a marked tendency towards hypersecretion of HCl is exhibited, and that is the carcinomatous ulcer of the stomach. On the basis of a fresh ulceration, or even on an ulcer scar of many years' duration, a carcinoma develops insidiously, and because of the hyperchlorhydria lets fall no suspicion of its true malignant nature until long too late for operative measures. All in all, it is by far the most difficult of the various forms of stomach carcinoma to diagnose at an early stage, and only a careful observance of the case and a close scrutiny of the history and course allows of the possibility of its early detection.

With the single exception of the carcinomatous ulcer, however, it is in our second subdivision, namely, stenosis with diminished or absent HCl, that the pyloric carcinoma as a class rightly falls.

It will thus be seen how much depends for an early diagnosis on a careful quantitative estimation of the amount of HCl contained in the gastric juice, and let it here be remarked, a single estimation in and for itself is of little or no value. The HCl figure we know from repeated examinations, even in apparently normal stomachs, to be exceedingly variable. In neurasthenic subjects we may often be surprised at times to find a total absence of the acid after a test breakfast, and a day or so later perhaps find it in normal amount, or even in excess. The nervous mechanism undoubtedly plays a large role in gastric secretion. Witness, in addition, the large number of cases of achylia gastrica nervosa running along many of them without symptoms, and discovered, perhaps, accidentally. There are no gross pathological changes to be found, but simply a condition of nervous insufficiency, what might be called a true stomach neurasthenia.

The absence of HCl in the gastric juice in these cases may be continued over many months, or even years, but the essential point in the differentiation from pyloric carcinoma is the variability of the acid figure, and the absence at any and all times of any well-defined signs of stenosis. For a diagnosis of carcinoma invading the pylorus, we must have not only a diminution or absence of HCl, but also some evidence of obstruction. And the acid must not only be diminished, but the diminution must be progressive and persistent, and when finally absent, as occurs in the later stages, must be constantly so.

If we observe a suspected case of pyloric carcinoma, let us say, for two weeks, and find after five or six examinations of the gastric juice during that time a successive diminution of the amount of HCl, be it but a little lower each time, our suspicion of malignancy has received strong confirmation. Kuttner has suggested an even better plan, at least theoretically. He proposes that three estimations of the acid be made daily for a short period, first in the morning on an empty stomach, then after the Ewald test breakfast, and finally after the Leube test meal. If our readings show a progressive diminution during the day, it speaks for carcinoma.

We have but to exclude in this connection a chronic gastritis advancing from the irritative or acid stage to the atrophic or anacid form. The diminution of the acid here is, however, not nearly so rapid, the disease picture is far different and there is no pyloric obstruction except, perhaps, in the extremely rare form of hypertrophic gastritis, which Boas has described for us.

These all-important quantitative tests for HCl can be easily carried out in any doctor's office. 10 *c. c.* of the filtered gastric juice is tritrated with a standardized deci-normal solution of NaOH., using Congo solution or paper as a convenient indicator. A reading of 20-30 *c. c.* of the NaOH solution used corresponds approximately to the normal amount of acid.

What has been said so far of HCl holds equally true for the other two digestive elements of the gastric juice, rennet and pepsin. As a matter of fact, rennet seems to be even more delicately affected by a malignant growth than is the acid, and its quantitative estimation, which is very simple, would therefore seem, and really is, even more valuable in the very early stages. It might be a matter of surprise that in all the discussion no allusion has as yet been made to lactic acid and the important role it is supposed to play. This is because the finding of lactic acid, though undoubtedly valuable for the diagnosis of pyloric carcinoma, is usually a late manifestation of the trouble.

Outside of rare incidental occurrences, there are three conditions necessary for the production of lactic acid in the stomach.

1. Hcl, or according to Strauss, even combined HCl, must be absent.

2. There must be a rather advanced stagnation of the chyme.

3. There must be an absence of the ferments as insisted upon by Hammersclog.

It will be seen at once that these three conditions are those met with at a more advanced stage of the growth. Still, I would not say by this that the finding of lactic acid is necessarily an indication that the tumor has advanced too far for medical operative interference. No such dogmatic assertion could be made, because there is clinical experience which speaks to the contrary. The tumor might easily cause a comparative early blocking up of the pyloric ring and show little tendency towards metastasis, as is the case at times with the scirrhus carcinoma.

Often before even minute amounts of lactic acid can be detected by the chemical test of Uffelmann, the Oppler-Boas bacillus, the causative agent, might be found microscopically. Their discovery then becomes of the highest corroborative importance in the early diagnosis of pyloric carcinoma, and must accordingly be sought for diligently.

When now we come to consider the next frequent clinical type of stomach carcinoma, the interosseal form, we find that much of the ground has already been covered in the preceding discussion. This refers more especially to the behavior of the gastric juice. No matter where the carcinoma is situated on the stomach wall, the inhibitory influence it seems to exert on the digestive elements of the gastric juice remains a never failing and constant factor. Exactly why the growth should thus affect the gastric juice so profoundly has never as yet been fully explained, but be that as it may, it is, with the single exception of carcinomatous ulcer, an invariable result and, further, may even occur in the later stages of a carcinoma far removed from the region of the stomach.

In the fundus or interosseal carcinoma we find, then, again, absence or diminution of HCl and the ferments, but unlike in the pyloric form, all signs of obstruction are lacking here, since from the very definition the orifice is not invaded. Herein lies the great difficulty in the early diagnosis of the interosseal form, for, as we saw above, the behavior of the gastric juice chemically is not of itself alone pathognomonic of carcinoma. There are other benign conditions, which may also be associated with a hypochlorhydria, and it was only when evidences of pyloric stenosis were likewise present that we were able to distinguish these conditions positively from malignancy.

How, then, can we separate the fundus carcinoma from the now malignant processes which exhibit likewise a diminished secretion of HCl? The problem is fortunately here greatly cleared by the character of growth which the interosseal carcinoma usually assumes. It is a clinical fact, be the reason what it may, that these growths are usually of the medullary or colloid type, and therefore prone to early disintegration and ulceration. The discovery, then, of the evidence of a breaking down of a carcinomatous mass, in the form of decomposing blood, and pus and perhaps cancer nests, becomes of the highest importance in the early diagnosis of this form.

Blood, in itself, is, of course, of not much diagnostic importance, since it occurs in many various other conditions, but pus associated with blood, or even by itself, tells a far different story. In gastric ulcer the pus expressed is of a negligible quantity and, in fact, in no stomach disease that could in any way be confounded with carcinoma, does pus appear in the gastric contents. The only remaining possibilities which might lead us astray comes from swallowed pus or pus that has reached the stomach from neighboring parts. Of high importance in determining the origin of the pus is the finding of columnar epithelium in its meshes, which, if present, would speak decidedly for carcinoma. Cancer nests, though of rare occurrence at an early stage, when found are, of course, at once absolutely diagnostic.

So important is the finding of pus and blood for the early diagnosis of the interosseal carcinoma that a passing word as to the best method of its detection might be pardoned. As with pyloric carcinoma, the best procedure is the siphoning off of the empty stomach before breakfast. The presence of food particles is, of course, here out of the question, because of the absence of stenosis, and, indeed, it is in these cases that we seem, at times, apparently unable to express anything from the stomach. Here is where caution is necessary. If pus is present, it is naturally in comparatively small amounts, and what little finds its way into the tube can easily be overlooked. A milking or blowing out of the tube should therefore never be neglected. One drop of a putrid pus is all that is required, other things equal, for diagnosis.

Pus and blood, it is true, may, in the same way, appear in the stomach contents in cases of pyloric carcinoma, or even in the cardiac form, but it is then a much later manifestation and has not the same broad, specific significance as in the interosseal carcinomas.

As a still further aid to diagnosis in these cases, we may find two special types of infusoria, which, when found singly or together, are well-nigh pathognomonic of a carcinoma between the orifices. These infusoria, the Tricomonas hominis and Megastoma entericum, are well supplied with flagellæ and are therefore, at body temperature, extremely mobile. They only occur in the stomach under certain conditions, which are the identical conditions produced by the interosseal carcinoma, and that alone. These are:

1. Absence of *all* acids, in fact the stomach must be alkaline.
2. There must be no stagnation.
3. The stomach must offer pouches or recesses.

That the stomach tends towards alkalinity in this type of carcinoma is not difficult to understand. Hcl is absent, and there being no stagnation, lactic acid and the whole series of other organic acids which arise from fermentation and therefore depend on stagnation are likewise absent. The infusoria, which demand an alkaline medium, are thus enabled to exist in the stomach, protected as they are by the hidden pouches which the cauliflower, or villous medullary carcinoma, affords. To Cohnheim belongs the credit of this highly important contribution to the early diagnosis of this not uncommon type of stomach malignancy.

Passing on now to the third and last of our division, the cardiac carcinoma, we find that a few words will suffice for its consideration. In point of fact, cardiac carcinoma should really come more under the head of an esophageal disease than a purely stomach one, since it presents all the characteristics of an esophageal stricture. Its differential diagnosis thus depends principally on the exclusion of all other possible forms of stenosis of the esophagus. Since the point of stricture, however, is at the lower end of the esophagus some 40 *c. c.* from the lips, the only common conditions which might confuse the diagnosis would be contracting scars following the swallowing of irritating chemicals, such as lye, and the hysterical spasm of the cardia. With poisons, the stricture is rarely so low down in the esophagus, and, besides, the history of these cases would certainly tend to clear up any existing doubt. In hysterical cardiac spasm, the age and sex of the patient, the discovery of other stigmata of hysteria, the more or less transient character of the spasm and its relaxation and final patency after persistent efforts perhaps with the largest of bougies, all tend to separate the condition from carcinomatous stricture.

When a patient, after forty, with no suggestion of hysteria, presents himself with a history of dysphagia coming on gradually, or even suddenly, our suspicions of malignancy should be aroused at once. When now all chemical insults to the esophagus can be excluded and a permanent, persistent stricture is found 40 *c. c.* from the lips, it is safe to diagnose cardiac carcimona. Even if we are able to make an early diagnosis in these cases, however, it is a question whether the location is not a rather too serious obstacle to radical excision. It would unfortunately appear that a patient with cardiac carcinoma is doomed from the very incipiency of his trouble.

That this doom should not, of necessity, likewise be set upon our cases of pyloric and interosseal carcinoma, it has been my purpose to show. Still, I am forced to confess, with all our finer methods in these cases, we are at times unable to make the much-desired diagnosis early enough for complete excision. The ground is, at best, a delicate one, and the disease does not always write its name in legible characters. There are cases which do not breathe a suspicion of malignancy until a rapidly developing anemia, let us say, or a sudden uncontrollable vomiting first suggests to the experienced the possibility of carcinoma of the stomach. Then, however, our diagnosis has come too late.

The workers in this field have not been blind to this phase of the problem, and have sought and are still seeking for one absolutely pathognomonic sign which would embrace all forms of stomach carcinoma at their incipiency. Up till now failure has stamped their efforts, but the prize is well worth the seeking and the field is broad, and, I might say, not unpromising.

Some years ago Solomon of Frankfort came forth with an ingenious idea. The pure gastric juice, we know, is free from any nitrogenous element, while the secretions of a carcinoma, or, better still, its toxins and disintegrating products, do contain nitrogen. On the strength of this, Solomon proposed that we cut off all nitrogenous food for 24 hours, and at the end of this time siphon off the stomach contents and determine the amount of nitrogen present by Kyeldhal's method. If the reading should be above 1/20 mgr, then carcinoma is present. Though cleverly conceived, this plan was found, after several trials in the German clinics, to be not at all pathognomonic of carcinoma. Ulcerations of the stomach walls of whatever kind, will also yield nitrogenous elements, and on the other hand a carcinoma of the stomach not in a state of disintegration will not respond to the test. The test is also somewhat impractical, since it requires for its execution rather complicated apparatus, found only in a large laboratory.

Somewhat simpler in execution, but likewise falling short of its purpose, was the proposed trypophan reaction. This, in brief, was based on the fact that the gastric juice digests the carcinomatous tissue and, as in all albuminoid digestion, trypophan is an end product and therefore would be found in the stomach contents in a case of carcinoma. Neither of these tests has proven to be of much broad, practical service, and, up till now, we are still forced to depend for an early diagnosis upon the characteristic findings of the stomach contents, as outlined above, and also to some extent on the history and general symptomatology of the case. I have purposely refrained so far from speaking of symptoms in connection with an early diagnosis, not that they should be disregarded altogether, but because in the initiatory stage they are too inconstant and vague to be of any positive value, except as forming the basis of a suspicion. The symptoms of stomach carcinoma as usually put down in our text books, refer more or less all to a period of the disease when radical operation is out of the question.

Still a history of a gradual and unexplained loss of weight with evidences of a beginning secondary anemia, both results of some deep-lying nutritional disturbance, should direct the attention immediately to the possibility of carcinoma of the stomach and especially if the patient be past the fourth decade of his life. At this stage, too, an unaccountable anorexia with an aversion and disgust for meat, as insisted upon by the German authorities, may also be taken as a strongly suspicious, and even confirmatory sign in the early stages.

But perhaps more striking than anything else in the history is the suddenness with which the disease seems to strike down its victims in apparently the very bloom of health. A patient, who perhaps for forty years never dreamed of the existence of his own digestive apparatus, will suddenly and without apparent cause, find himself the victim of a persistent dyspepsia, with pain, pressure, belching and other symptoms. Napoleon the Great, who, as you know, died of carcinoma of the stomach, is an historical example of this. In discussing the point with his physician Antommarchi, he claims, to quote from Osler, "that he had always had a stomach of iron and felt no inconvenience until the sudden onset of what proved to be his fatal illness." Herein lies an important fact to be remembered, and here, too, is where a fatal mistake is often recorded against us. These cases are treated for fermentative dyspepsia, lithemia, neurasthenia and what not, when, lo and behold! we are suddenly startled one day to find the outlines of a tumor in the epigastrium. It is a safe rule to regard every persistent case of stomach disturbance, especially after forty years of age, as suspicious of carcinoma, until, by examination and investigation, we can prove otherwise. The burden of proof should always be against carcinoma.

In conclusion, the claim is often made that in these days of advanced asepsis an explorative laparotomy will serve to clear up all the difficulties of the situation by allowing the surgeon himself to make the diagnosis. The value of an explorative laparotomy in all obscure abdominal conditions can not be denied, but here it is the rarest exception that the surgeon, of his own initiative, is able to make a sufficiently early diagnosis. One of the saddest incidents of the operating room and one not at all uncommon, is to stand by an eager spectator to such an exploratory laparotomy and hear the verdict, "too late for radical excision," pronounced against the patient.

Rather let us say, then, to the internist, with enlarging opportunities at his command, falls the duty of establishing the highly important early diagnosis and, when that is done, he will find in the surgeon, with well-nigh perfect technique already mapped out for him, a potent helper in the common cause.

DISCUSSION.

DR. J. A. STORCK.—I was pleased to listen to Dr. Simon's paper, but do not think that the finding of pus in the stomach contents belongs to the early diagnosis of carcinoma of the stomach. When found, it is usually late in the disease, and at a time long after that in which an early diagnosis is of importance. Scrapings from the growth are not easy to obtain in the early days of the disease, and, therefore, are not of much value in the early diagnosis of this condition. I think the Doctor made it a point that the presence of lactic acid was not of very much importance. To this, I cannot agree. Lactic acid, when persistently present in sufficient amount to be determined by Uffleman's reagent, along with the absence of hydrochloric acid and the ferments, and with or without the presence of Boas-Oppler bacilli, gives strong presumptive evidence of carcinoma of the stomach. Or, lactic acid alone with the classic symptoms of incipient gastric carcinoma, would justify a diagnosis of gastric carcinoma.

I think we should be careful how we express ourselves regarding cases of motor insufficiency with or without pyloric obstruction. The following case came under my notice, a case of motor insufficiency with a palpable tumor at the pylorus, hydrochloric acid reduced, small quantities of lactic acid present, ferments present. This case was thought by several physicians to be one of carcinoma. Gastro-enterostomy was performed, and a thickening of the pyloric opening found. Now, four years after operation, this patient is well and strong. This was probably a case of simple hypertrophic stenosis of the pylorus. We also see cases of simple myasthenia. I have seen cases of acute dilatation of the stomach, after typhoid fever, the dilatation being caused by the large quantities of milk ingested. Most of the cases recover fully under proper treatment. I think it will frequently be found that a careful history and the intelligent interpretation of clinical symptoms will often lead us to make as early a diagnosis, as mere findings by chemical and microscopic methods.

I quite agree with those who say that the persistent absence of hydrochloric acid, the absence or marked diminution of rennin and pepsin, the presence of lactic acid and the Boas-Oppler bacilli, with or without the presence of blood, means carcinoma. But, in how many cases do we get all these?

DR. SIMON (In closing).—So far as I know, the Oppler-Boas bacillus has been proved to be the positive cause of lactic acid formation in the stomach.

In regard to pus, I agree with Dr. Storck that it is of practically no value when the process is far advanced, but as regards the early diagnosis, it should not be lost sight of, as this is the first positive evidence of the interosseal carcinoma that we have.

I have little further to add as to the clinical symptoms. We have a good many confirmatory signs of carcinoma which, combined with the physical signs and laboratory tests as given before, enable us to tell almost positively before we hand the cases over to the surgeon, that he will find a carcinoma there.

The Comparative Frequency of Ulcer of the Stomach in the Caucasian and Negro Races as Determined Clinically.

By J. A. STORCK, M. D., M. Ph., New Orleans.

During my service in a negro female ward and clinic in the Charity Hospital, a service which extended over a period of several years, my attention was early attracted to what I considered a scarcity of ulcer of the stomach in the negro race. My interest once awakened in this direction, I determined to study the subject closely through my own personal experience, as I had vast material from which to draw observations. At that time, as my service comprised the only colored female medical ward in the hospital, all colored female medical cases came under my notice. I also saw a number of negro patients in my clinics at the New Orleans Polyclinic, and at the Touro Infirmary. Moreover, I sought information from my confreres through personal interviews and letters, and by means of a notice published in the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, after careful and extended inquiry, I have reached the conviction that my first inference upon the subject in question is correct; that is, that ulcer of the stomach is not as common in the pure negro race as it is in the Caucasian race, or even in the mixed white and black race. While in America we have no extensive, on the contrary, but little, data from post mortem records on ulcer of the stomach, yet we have clinical evidence from men who have seen great numbers of negroes and are well qualified to determine the disease. In my research here I have examined the records of the City Board of Health, and also those of the Charity Hospital. While the latter are of little value from a scientific standpoint, they afford an approximate idea of the comparative frequency of ulcer in the white and black races, *i. e.,* that ulcer is less frequent in the black race.

From the statistics of the Board of Health I gather the following data:

Total mortality from 1893 to 1903: Whites, 48,550; blacks, 30,012. Deaths from ulcer of the stomach from 1893 to 1903: Whites, 60; blacks, 13.

Along with my own records, my main reliance is placed upon the statements of other physicians who have seen active service among both whites and blacks. My own experience in the different institutions mentioned comprises a study of 11,700 cases, white and black, divided as follows:

Caucasian: Male, 800; female, 6,000; total, 6,800. Negro: Male, 200; female, 4,700; total, 4,900.

Cases of Ulcer—Caucasians: Males, 32; females, 26. Negro: 2 (mulatresses).

Deaths—Caucasians: Male, 2, one 74 years old and one 52 years old; females, 1, 33 years old. Negro: None.

20 to 35 years, 40 cases;
40 to 50 years, 18 cases;
50 to 74 years, 2 cases.

This shows a total as stated of 11,700 cases, of whom 60 had ulcer, a small percentage as compared with other sections of our own country and with foreign countries.

In my private practice the percentage of cases of ulcer in the white subject clinically recognized, is about 2%. The only explanation I can offer for the greater number of cases found in private as compared with hospital practice is the probability that the well-to-do and intelligent patient pays closer attention to his digestive organs.

Aside from what is stated in the foregoing, I have not been able to gather much reliable information regarding statistics of ulcer determined clinically. Lebert, in 41,688 cases, constituting the clinical material in Zurich and Breslau between the years 1853 and 1873, diagnosed 252 cases of gastric ulcer during life. I quite agree with Riegel when he says: "Reliable statistics that would enable us to formulate a judgment in regard to the frequency of ulcer in different countries cannot be arrived at in hospitals, nor in pathologic institutions, but must be gathered by physicians in general practice."

With this object in view, I had addressed communications to certain physicians whom I considered qualified to give me valuable information, and received the following replies. Dr. A. Pettit writes me: "In answer to your letter I will state that after a practice of 35 years, during which time I have attended a large number of the negro race, I have a distinct recollection of only one well-marked case of ulcer of the stomach. and that the subject was a male of pure blood and past the meridian of life."

Dr. E. R. Carson, of Savannah, Georgia, writes me: "But a month ago I saw in consultation a case which the post-mortem showed to be ulcer of the stomach which had perforated. Another medical friend tells me he had seen a post-mortem at the Macon City Hospital showing ulcer of the stomach in a mulatress. My idea is that the disease is by no means so common with the colored as among the whites. At least, that has been my experience."

Dr. E. A. Balloch, Washington, D. C., writes: "I can only recall one case in a negro, and the diagnosis in that case was clinical."

Dr. D. S. Lamb, of the Army Medical Museum, Washington, D. C., writing to Dr. Balloch, regarding my inquiry, says: "I do not recall any case of stomach ulcer in the negro; have found it many times in the white."

Dr. Geo. Bel says ulcer of the stomach is rare in the negro. It was with the greatest difficulty that I succeeded in gathering the little matter here presented, and I fully agree with Byron Bramwell who says: "I venture to think that there is perhaps no subject in the whole range of medicine on which the statistics are more uncertain than the subject of gastric ulcer."

As will be seen, the statements are based upon clinical observations entirely. My only reason for not presenting post-mortem statistics is that none exist which would be of any value as showing the relative frequency of ulcer of the stomach in the white and black races. And even regarding the statistics of gastric ulcer in the Caucasian, I believe that what Byron Bramwell says regarding the English hospitals will, for the most part, hold true of those in the United States, namely: "The post-mortem statistics from hospitals in this country are, for the most part, useless for determining the frequency of gastric ulcer, for until comparatively recent times, at all events, in many hospitals, it was not the custom to make a careful examination of the stomach in all cases examined post-mortem." So, when we find it necessary to use post-mortem statistics we are compelled to resort to other European sources. Those most generally quoted are those collated and analyzed by H. W. Welch. In Welch's statistics, which embrace 32,052 necropsies made in Prague, Berlin, Dresden, Erlanger and Kiel, there were found 1,522 cases of open ulcer or of cicatrix, presumably the result of former gastric ulcer. Therefore, ulcer of the stomach had occurred in 4.7 per cent (say roughly, 5 per cent.) of these 32,052 patients. Now, if we make a comparison of what has been determined post-mortem in white, and what has been determined clinically in the negro race, we find a marked difference in number between the two.

In searching for an explanation why the negro should be less liable to ulcer of the stomach than the white I could find nothing as set forth in the etiology of this disease by different authorities which would exempt him from this disease more than the Caucasian. The only explanation which I have now to offer is to hark back to the statement of Virchow in 1855, or earlier still to that of Moris in 1800, that "certain disturbances of the circulation in circumscribed areas of the stomach, such as aneurysmatic and varicose dilatations, and in particular, thrombosis and emboli are the most prolific causes of ulcer. Other authorities, Key for instance, attribute the origin of gastric ulcer to impediments in the venous circulation. More recently we have the statement of Riegel, who says: "It appears to me that many of the authors who have tried to explain the origin of gastric ulcer have not adhered to the facts of the case. An interruption of the circulation in any circumscribed area certainly leads to the formation of an ulcer whatever the cause of this circulatory disturbance may be." We have also the authority of Panum, Cohnheim, Doettwyler, Korte, Talma and others, that "the role of disturbances of circulation in the causation of ulcer has been established without doubt."

That the negro is afflicted with varicosities less frequently than the white has been brought out very forcibly by Matas in his work on the surgical pathology of the negro. Herewith I also present data of recent date obtained from the Charity Hospital reports:

From 1898-1903, varicose veins in the white, 57; in the black, 27; external hemorrhoids in the white, 100; in the black, 57; internal hemorrhoids in the white, 98; in the black, 48; varicocele in the white, 25; in the black, 7.

Now, if we put these two facts together, namely, that, as stated by Virchow and others, varicosities are a potent factor in the causation of gastric ulcer, and that the negro does not suffer as much from varicosities as the Caucasian, have we not here a probable explanation of the greater infrequency of ulcer of the stomach in the negro than in the Caucasian?

NOTE.—The article of Campbell Howard, of Baltimore, has recently come to my notice. He states that in the records of Johns Hopkins hospital he found that ulcer of the stomach is a little more frequent in the blacks than among the whites; but, we think that the number of negro cases upon which he based his conclusion was insufficient to be of much value.

DISCUSSION.

DR. E. M. DUPAQUIER.—On this subject I wish to state that from information gathered in the literature reports of hospital cases, I thought that syphilis of the stomach usually manifested itself in the form of *ulcer of the stomach.* I would be pleased to hear the Doctor answer this question, according to his information. I know of the case of a colored man who was treated for an ulcer of the stomach, namely, on account of his repeated blood-vomit, and who got well, at a point when he was thought to die, under the beneficent specific treatment. This simulated ulcer of the stomach was a gumma.

DR. A. C. EUSTIS.—I wish to co-incide with Dr. Storck's opinion that ulcer of the stomach is comparatively rare in the negro race. For the past two years I had a female negro ward at the Hospital, with 30 beds in it. These beds are usually full, and their occupants constantly changing, so that I had occasion to observe quite a number of these patients. I have been particularly interested in stomach cases, and have been on the outlook for them, but so far I have not found a single case of ulcer of the stomach among these patients.

Recovery of a test meal is often attended with great difficulty, owing to the weak suction action of the rubber bulb on the stomach pumps at present on the market. I have found, by attaching the stomach tube to a bottle, with an inlet and outlet tube to catch the contents, and by gradually producing a slight vacuum in the bottle by means of a Potain aspirator, that the procedure is greatly facilitated, without annoyance to the patient, by pressing on the epigastrium, the usual procedure.

DR. STORCK, (In closing).—The case referred to by Dr. Dupaquier was one of syphilis with mucous catarrh of the stomach. Ulcer of the stomach, due to syphilis, is a rare condition. I do not think that ulcer of the stomach necessarily has any connection with syphilis. If this were not true, I think that the negro would suffer more often from ulcer of the stomach.

I very seldom have any trouble in securing the stomach contents of my patients. In the majority of cases I use the expression method; but, when unsuccessful by this means, I use a Politzer bag for suction purposes. Care must be exercised whenever any suction method is employed, lest damage be done to the gastric mucus membrane.

Society Proceedings.

Orleans Parish Medical Society.

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141 Elk Place, New Orleans.
In charge of the Publication Committee, DR. ALLAN EUSTIS, Chairman
DRS. JULES LAZARD and H. DUPUY.

MEETING OF JUNE 24, 1905.

DR. A. JACOBY read a

Report of a Case of Acute Sciataca, with Treatment.

It is not my intention, in reporting this case, to go deeply into the subject, to discuss its etiology or pathology. What I purpose doing in this instance is to give the details of the treatment pursued in this case, so that a discussion of its merits or demerits and experience of others may be fully brought out. Neither have I entered into the literature on the subject, for this paper is not intended to cover any extensive grounds.

The patient presented himself at my house one morning in a state of agonizing pain, and his body very much bent, as if he were an old cripple. Recognizing that he was far more ill than he thought, I sent him back to his home, where I immediately went to see him. There I stripped him entirely and gave him a thorough examination.

Upon examination I found my patient of fair size, weight about 135, and of good muscular development. Muscle of the left thigh and leg seemed smaller than that of his right, and the gluteal muscles much smaller than those of the sound side. Pressure in the region of the sciatic notch the lower third of the thigh, and the calf of the leg gave him severe pain, and at times the pain in the hip and calf of leg were excruciating and unbearable. Drawing of the leg upwards with the knee stiffened and the patient upon his abdomen, gave him severe pain, as did the flexing of the thigh upon the abdomen. The difference in the examination of the two sides showed this remarkably. Upon the history of exposure and examination of the thigh and leg I came to the conclusion that I was dealing with a case of acute sciatica. He was a fireman by occupation, aged about 40 years, but had followed the trade of ship carpenter for the past three months, in which trade he was compelled to work in all kinds of weather. His past history was excellent, and he never suffered with any disease. The patient was not an alcoholic, but a user of tobacco in the form of cigarettes. In his trade of ship carpenter he frequently became soaked with rain or perspiration, in which condition he would return home.

In July, 1904, I was called to treat him for an evident severe sprain of the back, which I strapped with adhesive plaster and from which he had apparently recovered, except for some pain in the left hip. On February 1st, 1905, he developed sharp acute pains in the left hip, thigh, and calf of leg, but he continued to work till February 29, when, as he said, he could stand it no longer and consulted a physician. Not making satisfactory progress, and becoming dissatisfied, he consulted me on March 14th. The family was not in a position to go into a very expensive treatment, and was very much averse to any operative measure. I therefore ordered hot bottles placed along the entire course of the nerve and gave the following: Iodide of soda 7½ grns.; salicylate of soda 15 grns.; bromide of soda 15 grns.; citrate of potash 15 grns. Every four hours. This was later given every three hours. After three days I gave him a capsule of the following every two hours until relieved: Codein sulph. ½ grn.; caffeine citrate 2 grns.; phenacetine 5 grns.; antikamnia 2½ grns. This failed to give him much relief, and I was compelled to resort to the use of morphine gr. 3/8 by needle, when absolutely necessary. On the 17th, following the suggestion of S. Weir Mitchell and Clarke, who reported ten cases of cures out of twelve cases by the same treatment, in the *Lancet* of October 17, 1903, I put on a splint extending from the heel to the axilla, so that the limb would be absolutely immobile. This seemed to relieve him a little for the time, but it gradually grew worse and I decided since the family objected to any operative procedure being undertaken, except as a last resort, to inject the sciatic nerve with chloroform. Consequently, as nothing would relieve him except morphine, not even ½ grn. of codein and 15 grns. bromide of soda, given every hour for 15 consecutive doses, affording him but little relief, I injected, as well as I could determine, in the region of the sciatic nerve, at the junction of the upper and middle third of the left thigh, posteriorly, with the following: Spirits of chloroform (Squibbs) m. 10; cocaine 1% m. 20; adrenalin chloride m. 10; using an antitoxin syringe needle for the purpose. The puncture was sealed with collodion and cotton and never gave any trouble. Within 24 hours he felt some relief, and within 48 hours he required no more opiates.

The cocain was injected for the relief of the pain following the use of an irritant in the tissues, and the adrenalin chloride for the checking of any hemorrhage that might follow the puncture.

One must recognize that there is a considerable element of danger attached to this method, and that bad results have followed, probably owing to the injection of chloroform into a vein. This may be avoided, however, by the withdrawal of the syringe if any blood appears when the needle is inserted.

Twelve days after the splint was applied it was removed and two days later the patient was allowed to get up. His improvement was slow, but progressive, and he was discharged on April 17th, practically well. During his convalescence he was given tonics, massage, and hot baths. Unfortunately, he was not able to obtain electrical applications.

Of course, one can not draw conclusions from one case, but I feel that the result achieved in this particular instance and the immediate relief obtained makes it worthy of trial in any future cases. I do not say that it should be resorted to at once as an expedient, but after one has exhausted all therapeutic resources. One must recognize the dangers attached to such a procedure, which I am sure is far less than that of stretching of the sciatic nerve, and it should be considered before the major operative procedure. How chloroform acts in such a case I am not prepared to say, possibly in a similar manner to that of osmic acid as used by Murphy in trifacial neuralgia.

DISCUSSION.

Dr. Van Wart stated that sciatica is of interest to all medical men, and he was very much interested in the report of Dr. Jacoby. As far as his personal experience went, he had seen very few cases of acute sciatica, the majority of them coming under his observation in a chronic form. The pathology was obscure. The cases were either a simple neuralgia or a neuritis, more or less severe. Absence of reflexes would seem to indicate a true neuritis. As far as the etiology of the condition, he considered that most cases were secondary to some local pathological condition of the surrounding parts and insisted on the importance of considering sciatica as a symptom. Arthritis deformans of the lower part of the spinal column is a common cause, and is very often mistaken for a simple sciatica. In treating this condition, before any improvement can be expected it is necessary to immobilize the spine and heal the general condition present. Other conditions producing sciatica are tumors of the pelvis, constipation, diabetes, varicose pelvic veins and strain of the back. In treating sciatica the cause should be sought and, if possible, removed. In the acute cases which have come under his observation, the pain usually started in the region of the fourth or fifth lumbar vertebra, and a short time later the symptoms considered typical of sciatica manifested themselves. The injection treatment had been extensively used. Among the substances used were eucain, cocain, osmic acid, tincture of iodine and methylene blue. Many other solutions have been employed. The object of the injection is to place the solution as near to the nerve as possible. Intraspinal injections of cocain and salt solution had sometimes been employed, and beneficial results claimed. Injections of salt solution by the epidural method of Cathelin had also been employed. The time was too limited to even mention all methods. A method of therapy, with adhesive plaster, was described.

Dr. Cazenavette stated that numerous instances of injections in the treatment of sciatica are to be found in the literature. He thought, however, that before having recourse to any form of surgical interference, that the patient should be given the benefit of treatment by means of electricity. Of the different forms of elctrical currents, the galvanic and faradic have given poor results in his hands. But the employment of the static spark over the region of the sciatic nerve, has always resulted in prompt relief to the patient. This, therefore, led him to consider this the most advantageous form of treatment.

Dr. Halsey wished to concur with Dr. Van Wart's opinion that sciatica is very often a symptom of some other condition, in the majority of cases or arthritis deformans of the spine. During the past winter the speaker had observed two such cases in his service at the Charity Hospital. One case was a young Creole man who had been suffering from severe sciatica for two years previous to his admission to the hospital. A plaster cast was applied to the spine and in four or five days the sciatic pains had been greatly improved and in two weeks the patient was feeling so well that he deserted. He had come back to the hospital in a few months in perfect health, and with no return of the sciatic symptoms.

In arthritis deformans of the spine a bone formation takes place, which presses upon the nerves as they emerge from the spinal cord. By keeping the spine perfectly immobilized for a short while, nature forms a bony splint which relieves pressure upon the nerve roots. He considered that sciatica should be treated less by drugs and more by removal of the cause.

DR. HEBERT reported two cases of sciatica which he had observed during the past winter in the service of Dr. Elliott, which were apparently caused by uncinariasis, as by overcoming the parasites there was prompt relief, and maybe cure, as patient suffered no more while in the ward.

DR. SALATICH had seen four cases similar to Dr. Hebert's, in which the sciatic symptoms were relieved or cured after removal of the intestinal parasites.

DR. DUPUY reported a case of sciatica, or rather spurious sciatica associated with middle ear disease. The doctor, recognizing the hysterical condition, had treated the patient by suggestion, with a complete cure of the sciatic symptoms in four days. He thought many cases were purely hysterical in character, and could be relieved by suggestion.

DR. BARNETT recalled the case reported by Dr. Dupuy and stated that it was undoubtedly a case of hysterical sciatica, for he had relieved the patient by hypodermic injections of water.

DR. MAGRUDER reported a case of a boy suffering with sciatica who had made the rounds of the hospital and physicians' offices, and who was finally found to be suffering from a large pelvic sarcoma.

DR. GUTHRIE agreed with the previous speaker, who had urged seeking out the cause of sciatica, but he considered that there were many cases that come under observation in which no cause can be found, and which we must call simply "sciatica." These cases he had found usually responded to the high frequency of electricity. He always combined the electrical treatment, however, with proper diet and hygienic conditions.

Dr. LeBeuf reported several cases which had been relieved by an aged colored man living in the city, who followed the practice of mechanically stretching the sciatic nerve.

Dr. Barnett had also seen good results from continuous stretching of the sciatic nerve.

Dr. Van Wart, speaking again, stated he did not wish to be placed on record as advocating local injections as a routine treatment for sciatica, nor as favoring any one method. He considered that any treatment should take into consideration the etiology of the given case. Electricity relieved the pain in some cases, but it was hardly justifiable to regard it as a cure.

Dr. Jacoby, in closing the discussion, stated that he had sought for a cause in his case, but was unable to find any. He had tried suggestion on his case, but with no beneficial results. He did not favor the practice of stretching the sciatic nerve. He had tried injections of chloroform and cocain only as a last resort, and he thought that the results obtained justified publication of the case.

Dr. E. D. Martin read a paper entitled

Ethyl Chloride as a General Anesthetic.

(*Paper not handed in in time for publication.*)

Discussion.

Dr. Joachim, in opening the discussion, brought out the fact that this agent was given to the medical profession by some dental surgeon who had accidentally produced general anesthesia while attempting local anesthesia for the removal of teeth. It had been used for the past ten years in thousands of cases for general anesthesia. The ideal qualifications which it possesses of rapid effect, rapid recovery and, above all, its safety, fulfill all requirements for general anesthesia in painful but short operations, such as those upon the ear, nose and throat which the specialist often performs.

In addition to fulfilling these requirements of the specialist, this agent can be used while the patient is in the upright position, the fullness or emptiness of the stomach are of no great consequence when using this anesthetic, it does not abolish the throat reflex and produces an analgesic effect which outlasts the period of unconsciousness. If given on a well-protected Esmarch inhaler, only one-half to five or ten grams are needed, and no cyanosis, salivation nor muscular rigidity results. It should not be given to alcoholics, hysterical patients or patients in a state of fright. When given, a second or third administration of the anesthetic is not dreaded by the patient, as is the case with other general anesthetics. The awakening of the patient is quick and pleasant, a certain absent-mindedness, however, lasting for five to fifteen minutes, often being noted. The after-effects are mild, as compared with other anesthetics. Four cases of death have been reported up to the beginning of this year. Only one case, however, is not open to doubt as to the influence of the anesthetic and in this case such lesions were found as would probably have produced death from the administration of any other general anesthetic. The death rate of 1 in 16,000 for ethyl chloride anesthesia is probably too high, in view of the extensive use given to it at present, and the frequency of fatal reports. There is not the cyanosis observed with ethyl bromide.

After comparing its relative value with the anesthetics usually employed, and the relative death-rate, Dr. Joachim stated, as his conclusion, from his own and the experience of others, that for short operations ethyl chloride produces a quick anesthesia, permits a quicker awakening, is free from untoward after-effects and comparatively safer than other anesthetics.

Dr. Gordon King had had only a limited experience with ethyl chloride, but he had used ethyl bromide as a general anesthetic in a large number of cases, some 6,000, without a fatal result, and he was a strong advocate of this drug as a general anesthetic. As far as the advantage of ethyl chloride over chloroform, ether and other anesthetic mixtures, ethyl bromide possessed the same advantage. He does not think, as Dr. Joachim, that ethyl bromide suffocates. However, the anesthetic does decompose on exposure to air, and the custom which he followed is to procure it in hermetically sealed tubes containing one ounce. Half an ounce is the usual amount required for each case, and after a tube is once broken and a portion of it used, it is thrown away. Ethyl bromide is also administered with the Esmarch inhaler. In giving the anesthetic he had noticed that the conjunctiva becomes suffused, showing a dilatation of the capillaries and arteries. He thought that probably this accounted for the fact that these two anesthetics could be given the patient in the erect position, on account of the less likelihod of anemia of the brain. He stated that the laryngeal and pharangeal reflexes are not abolished, and considered this an advantage, for as soon as blood enters the larynx it is coughed out. For this reason he does not employ the Rose position, which the Northern specialists, who employ ether, are compelled to adopt.

In the 6,000 cases under his observation only one manifested any ill effects. This patient was just recovering from an attack of measles, and after taking a few whiffs of the anesthetic, pulse and respiration became embarrassed. After inversion of the patient and artificial respiration, these symptoms were overcome and the anesthetic was continued without any further difficulty. He was very much interested in the reports of the use of ethyl chloride, but until more cases were tried he did not feel justified in changing from ethyl bromide.

Dr. Dupuy wished to take exception to the remarks of Dr. Joachim, that ethyl bromide produced cyanosis. He had used ethyl bromide and he had never observed this fact. He had talked with Dr. Martin about the use of ethyl chloride, and the latter had told him that ethyl chloride destroyed the reflexes which ethyl bromide did not do. This was an important point in the employment of an anesthetic in operations on the nose and throat, as it is of great assistance to have the reflexes intact. He considered that the results of the 6,000 cases reported by Dr. King were the best argument in favor of ethyl bromide.

Dr. Joachim, in closing the discussion, said that he had stated clearly that ethyl chloride did not abolish the reflexes, nor even response to energetic speech. In speaking of the cyanosis and rigidity produced by ethyl bromide, he had reference to the choke method of administration of this agent, which was the usual way. He was pleased to hear that these symptoms were partially or entirely absent when given by the drop method on the Esmarch inhaler. The great points of advantage over ethyl bromide are the small quantity necessary for producing anesthesia (from ½ a gram for a child to 10 grams for an adult), as compared to ½ an ounce of ethyl bromide, as stated by a previous speaker, the palatability of the dosage and the lesser mortality. The total number of administrations of ethyl bromide, mentioned also by a previous speaker, had not yet reached a number where a fatality might occur.

PRESENTATION OF CASES.

DR. GUTHRIE exhibited *a Case of Hanot's Disease*, with the following history:

White male, aged 23, had complained of jaundice for the past five years. Hereditary history negative. He had had typhoid at nineteen and had been partially deaf ever since. He had had constant jaundice for the past five years and occasionally vomited after meals. Bowels regular, two stools a day, and always yellow. He was a laborer and had been working with lead. Patient presented decided jaundice, and there was a marked cardiac pulsation, extending from the apex to the junction of the stermum and the third rib. There was no cardiac murmur. The liver was enlarged, measuring 8 inches in the median line, 9¾ inches in the mammary line and 10 inches in axillary line. On palpation the liver appeared smooth, there was no nodular appearance of the organ. Spleen was likewise enlarged. There was bile in the urine and feces; 11,000 white blood cells per cubic c. m. of blood, there was enlargement of the superficial epigastric vein, but apparently the blood current through these veins was in the normal direction. There was no history of syphilis or alcoholism and no plasmodia malariæ in the blood.

He had presented the case to the Society because cholecystotomy and subsequent drainage of the gall bladder into the colon was contemplated. Of seven cases of Hanot's disease treated thus, three have recovered, and with the hopeless results of all other therapeutic measures he thought this operation justifiable.

DR. HALSEY spoke of the rarity of this disease and thought that this was sufficient excuse for presenting the case to the Society.

DR. EUSTIS wished to know if specific treatment had been tried in this case, and reported a case presenting similar conditions, with no history of syphilis, which had occurred in his service at the hospital, which had been greatly improved by mercurial inunctions and the internal administration of iodide of potash.

Dr. Guthrie, in closing the discussion, stated that the anti-syphilitic treatment had not been tried as yet, but before operation was performed it would be given a thorough trial.

Relation of Cases and Medical News.

Dr. Salatich reported

Case of Cerebrospinal Meningitis,

following typhoid fever. There was no involvement of the middle ear and it was evidently a result of the typhoid infection.

Dr. Joachim reported a case of a woman, still under observation, *with tumefaction* over the left frontal sinus, tenderness over the maxillary antrum of the same side, offensive discharge from the left nostril. Local inspection and transillumination gave sufficient reason for a diagnosis of chronic empyema of these cavities. The maxillary antrum, full of extremely fetid pus, was opened after Jansen's method, with establishment of free drainage through the inferior meatus. The frontal sinus was incised according to Kolvan's method. Encountering unusual bleeding and finding the frontal wall perforated, and to a great extent softened by disease, this plan had to be abandoned. The entire cavity of the large frontal sinus was occupied by a centrally disintegrated mass of tissue, which could be removed singly and completely from the underlying structure. Further steps were postponed until the nature of the tumor had been established. It proved to be a typical epithelioma.

Dr. Lazard reported

A Case of Epithelioma

involving the penis, scrotum, and perineum. The inguinal glands were enlarged. Complete emasculation was performed. The meatus was included in the growth and a sound could not be used in outlining the urethra. Urethra was dissected for in the perineal region, at its bulbous portion. It was dissected from the corpora cavernosa by a pair of curved scissors and turned downwards. The corpora cavernosa were separated from the rami in the usual way. Inguinal glands on both sides were dissected and the supra pubic fat and skin of perineum were removed. The scrotum and testes were removed, the cord ligated high up at the rings. This left a very large gap devoid of skin. The wound was closed by suturing the skin of the inguinal region over the pubes. The perineum was covered by loosening the skin of the inner surface of the thigh, with which it is continuous. The urethral opening was sutured to the perineum in such a way as to have adhesion of the mucous surface with the skin, to prevent subsequent atresia.

MEETING OF JULY 8, 1905.

PRESENTATION OF CASES.

DR. VAN WART exhibited two cases of Multiple Sclerosis.

DISCUSSION.

DR. CAZENAVETTE stated that multiple sclerosis forms the great majority of cases in his clinic at the hospital and he had noted that there is almost universally scanning speech. From his experience in these cases he considered exposure to be the etiological factor more often than alcoholism.

DR. DABNEY had noticed that these patients are usually very cheerful and it is difficult to make them realize the seriousness of their condition. He wished to know whether Dr. Van Wart had noticed this in these two cases.

DR. VAN WART, in closing, said that he had seen at least ninety cases of multiple sclerosis since coming to New Orleans, in which the diagnosis was beyond question, but that after careful interrogation he was unable to find any one particular etiologic factor. Replying to Dr. Dabney, he stated that the first patient presented is a longshoreman and that the patient does not consider he is very ill. The second patient is a machinist and is apparently very cheerful as to his condition. He had seen many patients who were very much depressed and mentioned also apoplectiform and epileptiform seizures occurring in the course of the disease. He reported a case which was reported by an Atlanta physician as being cured of epilepsy by dilatation of the sphincter ani, who had later come under his observation and was found to be suffering from well-defined multiple sclerosis. Regarding the treatment of multiple sclerosis, he was of the opinion that drugs were of no avail.

Dr. Gordon King read a paper entitled

"The Importance of Slight Degrees of Deafness in Children."

In selecting this subject for your worthy consideration, I have, perhaps, diverged somewhat from the plan we are customarily inclined to follow of basing our remarks upon the observation of some unusually obscure or rare case, or the exposition of some new method of medical or surgical treatment, which may have met with favor or disfavor at our hands; or, when we are fortunate enough, of enlightening the minds of our brother physicians with some personal discovery redounding to the benefit of humanity and the glory of the profession. I must beg your kind indulgence, therefore, while I course over old pathways in an honest endeavor to bring to your mind some facts of very practical value, which, from their apparent unimportance, may have been overlooked in your study of the diseases of childhood.

It is not the writer's intention to consider here the pathology and treatment of the severer forms of ear diseases in children, but rather to impress upon you that perfect hearing is one of the most important factors in the intellectual and moral development of children, that even moderate degrees of deafness may seriously influence a child's career in after life, and that it is the duty, furthermore, of the physician, the parents and teachers to recognize and, if possible, rectify such defects.

To give at once some idea as to the importance of this subject, and its relation to child instruction, I should begin by informing you that at least 20% of school children examined at large, have defective hearing. This may seem to you an exaggeration, but statistics have proven these figures to be even a modest average; thus, Reichart, of St. Petersburg, examined 1.055 children, and found 232 with defective ears, which gives a percentage of 22. Weill, of Stuttgart, who examined 5,095 children, found 30%, or more than 1,500 were deficient in hearing power. Gelle, among the school children of Paris, discovered 22% to have some degree of deafness. Dr. Bezold, of Munich, in Bavaria, who is another renowned aurist, reports that about 21% of over 1,900 children examined there were afflicted with deafness. These statistics, made by excellent authorities in different countries, are not to be doubted, and the tests made by them are of the simplest kind, such as any intelligent person can readily make, as I shall endeavor to show you. First, let us understand clearly the degree of deafness alluded to in these statistics, which gives us this remarkably large percentage. To begin with, we may eliminate all cases of severer deafness, for children so afflicted are not sent to school, or if so, do not remain there, but are cared for in institutions where special methods of instruction are carried out for their benefit. This class of cases we are not to consider in this connection, but all others whose sense of hearing is not up to a standard, we may designate as the normal degree of hearing, we are at liberty to class among the deficient. These children constitute a special type that the French have termed "Les sourds de l'Ecole." Even now, you may still entertain some doubt that so large a percentage of children are considered deaf, but that is because you may not have given this subject the proper attention. Scores of people we meet every day have deficient hearing, and yet we may never be conscious of it, because they appear to hear ordinary conversation and the other usual sounds about us. Some of them are, perhaps, themselves, unconscious of the fact, unless they have been subjected to a test. If, then, you may inquire, such people are unconscious of their deafness, and are apparently so little hampered by it, why should we lay any stress upon the importance of it? The answer is this: A child, especially when at school, to be on equal footing with others of his class in his effort to acquire knowledge, must be in full possession of his faculties, must have his special senses, which are the means by which he gains knowledge, in a state of normal activity. If his sense of sight is deficient, if his sense of hearing is below the hearing of his classmates, he is held at a natural and obvious disadvantage, and unless endowed with special brilliancy of intellect, is sure to fall behind, and become a laggard in the class standard. As attesting to this fact, statistics again prove that it is among the last grade of the class that the deficient in hearing are almost invariably found, and further, that the greater the degree of deafness, the lower is the class standing of the one so afflicted. Unfortunately, it too often happens that the physical deficiency of these poor children is not recognized, their inaptitude is attributed to lack of mental capacity, or activity, and they are looked upon as hopeless laggards in school, and become real laggards in after life. Even the mothers, who are the keenest observers of the faculties of their children, too frequently overlook the lighter forms of deafness, and attribute it to *inattention,* or lack of interest on the part of the child, and are content to seek no further explanation. The mind of a child is normally active, his senses keenly alive to new impressions, and each impression excites new emotions which keep up a state of mental receptivity favorable to the acquirement of knowledge. Inattention, or a want of proper interest in its surroundings, as an habitual characteristic in a child, usually means one of two things, deafness or mental inactivity, and it is not difficult to determine which of the two is responsible. To the child's guardian or teacher must fall this task, for it is in school that the child suffers the greatest disadvantage from his weakness of hearing, unless that defect is duly recognized, and the proper consideration accorded it in the class room.

The pupil, whose acuteness of hearing is not sufficient for him to follow the oral lesson without effort, experiences difficulty in following and comprehending long or rapid phrases coming from his teachers, and becoming discouraged, loses interest, and his mind wanders from the theme. In the words of Itard, "If to listen is a source of pleasure for a child who hears distinctly, it is on the contrary a source of fatigue, a continual effort for the child who hears confusedly. In childhood, all that is not heard distinctly gives place to that which is heard and every phrase, incompletely heard, is a phrase lost. The words of the speaker are no longer listened to, because they require too close and prolonged attention." As a consequence of this, the lesson is lost to that child, his attention is attracted to other things, and he becomes not only a laggard, but often enough the mischief-maker of the school as well. This disadvantage on the part of the deaf pupil becomes more apparent still, when the higher classes are reached and more concentration of mind and steady application are required to solve problems and comprehend the discourse of the teacher. Handicapped by his physical infirmity, he is obliged to give more time to the study of the texts than his more fortunate fellow students, and for this he must be endowed with a special pride and ambition which he may not possess.

Therefore, it is plainly the duty of those who have the best interest of their children at heart to examine into the physical aptitude of each one, and if there be any who prove by the simple tests applied to be deficient in hearing power, such measures should be adopted to rid them, if possible, of the deafness, or at least to put them on a more equal footing in the class room with other pupils of their grade. In the writer's opinion, every school should make it a standard rule that when the pupils are being enrolled at the beginning of the session, and are being assigned in classes, according to their relative grades, all should be carefully examined, and those sought out whose physical defects are to retard them in their future work. The test of hearing to be made is exceedingly simple, and does not require the skill of the trained specialist.

All that is required is an ordinary watch and the human voice. Any watch may be used for the purpose, it being necessary to first ascertain the average distance at which that watch is heard by several persons with normal hearing, and that distance is taken as a standard by which the defective ears are detected. The child to be tested is taken into a quiet room, with doors and windows closed, to exclude sounds from without, made to sit near the center, away from sound-reflecting walls, and the eyes being closed, is told to listen to the tick of the watch. The watch is then held at a distance, and gradually approached to the ear from the side until the sound is heard. This is to be repeated two or three times to be sure of the correctness of his answers. The other ear, meanwhile, is tightly closed with the finger, or a plug of wet cotton. The greatest distance at which the watch is heard is then measured with a rule or tape, and compared with the normal standard. A very slight degree of deafness may be detected in this way, which, though it is slight, may mean most serious hindrance to the pupil's progress, or be the beginning of severer deafness to develop in the course of time. The watch test is not considered altogether adequate, however, for the reason that a person may be affected with what is termed "tone deafness;" that is to say, his hearing may be only deficient in the perception of certain notes, and for some the tick of the watch might correspond to that missing tone and the hearing be otherwise normal. On that account, the distance at which the conversational tone of voice is heard is used as a measurement. The child is made to stand at one end of a long room, facing at right angles to the examiner, with the opposite ear closed. The examiner, then, in ordinary conversational tone, calls the names of familiar objects or numbers, and the child is told to repeat the words he hears distinctly. The standard distance of the voice having already been ascertained, it is easy to measure in paces or feet the distance at which the child hears it in each ear, and make the comparison. The method commonly employed in schools abroad, where attention is given to this important matter, is what is known as the black board test of dictation. In this the pupil is able to write, is put before a blackboard, given a piece of chalk, and told to write down words dictated in ordinary tones by the examiner. The examiner then dictates the words from behind the pupil, and advances or retreats until the distance at which he hears distinctly is correctly ascertained. This is a quick and practical test, though not as accurate as the one just described.

Once the deaf pupils discovered, what remains for the teacher to do to make their deficiency less burdensome to them? First and foremost, let their parents and guardians be notified that the proper measures be adopted to relieve them, if it is possible, of their deafness. If they cannot be relieved, then the teacher should make such concessions for them in the class and lecture room as will enable them to hear and attend to the discourse of the teacher. They should be given places in the class room of the best acoustic advantages, according to their individual degrees of deafness, that they may be on more nearly an equal footing with their more fortunate class mates.

As to the prevention and cure of deafness, it is an important fact to remember that a large majority of cases of deafness have their beginning in some disease of the ear during childhood, and early youth, and that it is during this stage of life that these diseases that affect the hearing may be best prevented or cured. Also that a weakness of hearing in childhood becomes too often the incurable deafness of adult age.

DISCUSSION.

DR. DUPUY remarked that Dr. King struck the keynote of his paper when he said that knowledge is gained chiefly through the avenue of the special senses, and hence even slight degrees of deafness in children is of the utmost educational importance. Causes of slight deafness in children must be divided into two classes, the inflammatory and the non-inflammatory. Under the first, acute catarrhal inflammation is paramount. Many cases of acute otitis media occur with very little pain and with no perforation of the drum membranes. This is specially so in low grade inflammations. Repeated attacks, however, of these mild inflammations leave their impress on the middle ear, causing changes in the tissues, resulting in slight impairment of hearing. If the drum is incised in this affection, only a clear serum may escape, showing, nevertheless, a definite acute inflammatory condition.

Among the non-inflammatory causes, adenoids are foremost as an etilogic factor. These growths impede nasal breathing and sometimes even press upon the opening of the Eustachian tubes and thereby prevent proper ventilation of the middle ear.

Palliative methods alone should not be resorted to in the treatment of earache in children, as most earaches in children must be regarded as due to an active inflammation; therefore incision of the drum is indicated in the great majority of such cases. A pure otalgia, that is, a neuralgic affection, is extremely rare in early life. Laudanum and sweet oil are much abused. The physician who first sees these cases bears the burden of responsibility.

DR. GESSNER descried the habit which some physicians have of temporizing with cases of disease of deformity in children, assuring the family that the trouble would soon "pass off." He thought that this loose habit should be frowned upon by the profession, as it results in much harm from quite easily remediable conditions.

DR. BRUNS wished also to condemn the practice so common amongst the laity of treating earache in children with oily preparations. In his earlier practice he had been compelled to treat the ear as well as the eye and he was struck by the great number of cases of aspergilius which came under his observation when this treatment had been resorted to by the family.

Dr. Oechsner mentioned the fact that many of these cases of acute otitis media result in spontaneous rupture of the drum membrane after suppuration. He wished to know the prognosis when spontaneous rupture had taken place. He made it a practice to wash out the ear with warm water until he could refer the case to a specialist.

Dr. Dabney thought it was a mistake to advise the mother to wash out the ear of the child, as it was by no means a simple operation when performed by an inexperienced person. He always instructed his patient not to put oil in the ear and not to wash it out, but to consult one duly qualified.

Dr. Lazard said that the general practitioner was often called upon to treat cases of earache at an hour when it was impossible to have a specialist incise the drum membrane and he wished to know what was the best palliative treatment until the patient could be referred to a specialist.

Dr. King, in closing, stated that the prognosis in cases of suppurative otitis media tends upon the virulence of the infection, typhoid and scarlatinal infection being particularly unfavorable, even though incision of the drum is practiced early. Ordinary cases of otitis media treated early by incision usually recover without any subsequent deafness; but if allowed to run along, deafness almost universally results. He thought that few practitioners of the present day resort to oil and laudanum in the treatment of earache, but that most of these cases so treated were prescribed for by druggists. The oil not only favors the development of the aspergilius, but it also forms a smegma in the ear and occludes drainage. He advised early incision of the drum membrane in all cases of earache and condemned the use of morphin for this condition. The best drug, locally, is cocain; but this is not absorbed by the inflamed membrane, and where we wish to produce anesthesia, the cocain is dissolved in a mixture of anilin oil and alcohol. He preferred dry heat to moist, locally, to relieve pain, as the latter favored spontaneous rupture of the membrane. These spontaneous tears are slow in healing and many do not heal at all. Hot water injected in the external auditory canal will often relieve the local pain, but after the injection the canal should be thoroughly dried with cotton. Where there is no involvement of the mastoid cells, cold applications can be used.

In concluding, Dr. King stated that it was not the purpose of his paper to consider the treatment of deafness in children, excepting in so far as prophylactic measures were concerned.

Dr. Landauer read a paper entitled

"Carcinoma of the Cervix."

The subject chosen for this paper tonight is carcinoma of the cervix, with special reference to the diagnosis; and in choosing this feel that I should apologize for not offering you anything new, but I have personally had three cases to so well illustrate what I wish to bring out is the reason. Is cancer curable? This is a question so often asked us, and one which we hesitate to answer; we read that it is; we are told so by our teachers, but when it comes down to actual practice, what is our experience? It is easily answered; most of the cases operated on die within two years, so what have we accomplished? Why have we submitted the patient to the severe ordeal of such an operation, merely to prolong life for a year, or to lessen pain? Then, gentlemen, unhesitatingly I say we should not advise the patient to submit to such a dangerous operation, when we can not offer any hopes for a cure. This certainly does not apply to emergency cases, where we operate to control certain symptoms, as severe hemorrhages, which would take the patient away so suddenly. What, then, must we do, leave these cases to die, and not try to save them? Again I tell you unhesitatingly no. What, then, should we do? Gentlemen, our duty seems to me quite clear; we should be ever on our guard never to prescribe or treat a case without the most careful examination, so as to enable us to make a diagnosis as early as possible. What are the very earliest symptoms which one should expect to find? We don't, or rather should not, look for pain, because that comes rather late, and is caused by the eroding of a nerve, or the secondary infection spreading to the ovaries, or tubes. In my experience the history will often aid us a great deal. By careful enquiry, or possibly without any questioning, patient will tell you that her menstruation had always been regular until a few months back, then she began to notice that one time it would last three days, the next time five or six days, in other words, she has begun to have hemorrhages, but only when the uterus is congested at the time of menstruation. After menstruation very often some leucorrhœal discharge, which may have very slight odor, not enough to cause her to note it, nor the attending physician, unless he directs special attention thereto. Again, she may tell you her menstruation is regular, lasting from three to five days, not profuse, not painful, and no leucorrhœa, but each time after coitus, she notices some blood, very little. possibly, but enough to cause a stain. Now, in a woman previously regular as to menstruation, and normal in other respects, such a history should cause you to be on your guard. Now examine with a bivalve speculum, or a Sims specula and vaginal retractor, you find an ulceration; the majority of times this will be simply benign, but occasionally it is not. You can very easily take a section and send to the pathologist and get a report; if benign, use conservative treatment, or if your judgment directs, an amputation; on the other hand, if malignancy has been reported, you can hardly be too radical; nothing less than a total extirpation of uterus, ovaries and tubes, being careful to take out as much of the hard ligaments as you can. Search carefully for any enlarged glands deep down in the pelvis, and remove any if found, and even do ligation of the iliac. To some of you this may seem too heroic, too radical, but you should remember we are dealing with a deadly disease, and we must do everything possible to eradicate this entirely. If we have been fortunate enough to procure our case in its incipiency, we can surely expect a cure. The trouble with the majority of us is that we expect a clear text-book case, all symptoms typical; wait long enough, and we will get it; but then while we are waiting for the hemorrhages, the cachexia, the loss of weight, the metastatic growths, etc., we are wasting precious time. When we get that far our patient is beyond the hope of a cure. The only time we can expect such results is very early, before the lymphatics have had a chance to take up this infection and carry it to any other parts. I reported to you some time ago an early case of adenocarcinoma, unoperated, and had chance to see that patient nearly a year later, when we did not need the microscope to aid us. She died about five months ago, having lived only about eighteen months from the time she first noticed the hemorrhage. Since then I have two other cases, and through the kindness of Dr. C. Jeff Miller, I can add a third.

His case first, the details of which he can give you more accurately than I.

She was perfectly well as far as she knew; the only thing that worried her was after sexual indulgence she invariably noticed a small quantity of blood, just enough to cause a stain, and for this she sought medical advice. On examination, only a small ulceration was found, but a section was taken and malignancy reported, a total hysteretomy was done, with the result now, eleven years later, no recurrence.

Case 2: Young married woman, age 34, mother of two children, youngest five years old, no miscarriage. Both labors normal, though the first was painful, and lasted five hours; past history good; never ill. Family history, both parents living and well, no sisters or brothers living, one sister died early of scarlatina. As far back as she can trace, no cancer or tuberculosis in the family. She first noticed last July some irregularity in menstruation; would expect at the first of the month, sometimes it would not appear before the middle or last; sometimes would last several days, longer than previously, from three to eight days, being what she now menstruates. No pain. Some leucorrhœa, but not much, and no perceptible odor.

On examination, the lower lip, on patient's left side, showed the scar of a former tear, which had been left to nature to repair. At the seat of this scar was an ulcerative process, possibly two inches long by half or three-quarters broad. A section was taken and examined, and carcinoma was reported. I did a complete hysterectomy. This was last October, and up to now no recurrence.

Case 3: Patient is a widow, 28 years old, colored; had one child seven years ago; no miscarriage. Past history good. Family history negative as to cancer or tubercular troubles. Present trouble began six months ago, with some irregularity in menstruation, as the second case, but this was overlooked, but three months ago began to have pain in lower left side, and for this she consulted me; found there an ovarian cyst as large as an orange, and a smaller one on right side. But the lower portion of posterior lip also showed a scar of a former tear, and ulcerated. This, too, was reported malignant, and a complete hysterectomy done. Result, completely cured of all pain, but too early to say about recurrence, but none so far. To these I can add one from Dr. Wm. R. Pryor, New York. His case was very similar as to history, and he did a complete hysterectomy, ligation of iliac, with the result that there was no recurrence four years later; have not heard for eighteen months.

Have also a case from Dr. Karl Abel's clinic, Berlin. The history here was similar, and a total hysterectomy done with the result that one year later no recurrence.

It is true, gentlemen, that I have given you only five cases, and that is too few to draw conclusions, but it should impress on your minds that carcinoma is curable; but only in the very earliest stages, and to hope to get it in this stage, we must keep our eyes wide open, must call in the pathologist for every case of ulceration, and whenever malignancy is reported, or even suspected, be radical, or don't touch it.

Another point which has attracted altogether too little attention, and that is the prophylactic treatment. By a careful analysis of statistics, you will find that 98% of cancers occur in women who have borne children, have been lacerated and not had the repair attended to, and this, then, offers us the first point: repair every tear before discharging your case.

In conclusion, gentlemen, let me refer you to a most excellent monograph by Samson, which appeared in the columns of the *Journal of A. M. A.*, May 20th, on this subject.

DISCUSSION.

DR. SHLENKER referred to the statistics of Sampson, who had made a careful study of cases of carcinoma of the uterus and found that sixty per cent. of those cases referred to him for operation manifested glandular involvement. Of these cases, 75 per cent. died or had recurrence of the disease. The speaker considered that a vaginal discharge was one of the earlier symptoms and that hemorrhage and pain was a late manifestation. He believed that the pathologist could not be called in too early.

Dr. Oechsner considered that the only chance of curing these patients by operative measures is to operate before the appearance of any gross lesions. He brought out the point that most cases of carcinoma were the result of traumatism, hence the importance of avoiding this factor on the part of the general practitioner. On the tenth day following parturition, all tears should be thoroughly sutured. All surgeons agree that the best time to operate on cancer of the stomach is to operate on the pre-existing ulcer, and the speaker thought that the same conditions obtained in carcinoma of the cervix.

Dr. Gessner, referring to taking specimens for microscopic examination, warned the members that this should not be done unless a radical operation was to follow shortly, as it might promote the spread of the disease by carrying its elements beyond the area already involved.

Dr. P. L. Thibaut spoke of the danger of relying implicitly on the microscopical diagnosis. He referred to a case of his from whom he had removed what he thought was a uterine polypus. This, on examination by two different pathologists, was pronounced an adeno-carcinoma. Accepting the microscropical diagnosis, he had urged a radical operation, which was indignantly refused by the patient. The patient recovered without any further treatment and has been in perfect health for two years following the microscopical examination and with no evidences of local malignancy.

Dr. Lazard referred to the fact that when a student at the hospital he had observed that Prof. Lewis always attached more importance to his clinical diagnosis than to the histological examination.

Dr. F. H. Watson, replying to the two previous speakers, stated that the examination of uterine scrapings is one of the most difficult tasks which confront the pathologist. Chronic endometritis and glandular hypertrophy are often at first glance identical with the histological picture of adeno-carcinoma. More minute and careful examination directed toward (1) staining properties of the individual cells, (2) infiltration, (3) Karyotinitic figures, will differentiate between them. A positive diagnosis can be made by microscopical examination. A positive diagnosis of early carcinoma cannot be made without such examination.

Dr. Landauer, in closing, said in reply to Dr. Shlenker, that he did not say that hemorrhages were an early symptom of the disease, but that there was a tendency to menorrhagia. Carcinomatous cases operated upon after glandular enlargement seldom gain more than one year, and he did not consider it justifiable to submit a patient to such a severe operation for such a small respite. If all lacerations of the cervix were repaired early, the number of carcinomatous cases would undoubtedly be reduced. Dr. Sampson, he said, claims that he had never seen a case of carcinoma uteri in a woman who had not borne children, and, personally, I have never seen one. Replying to Dr. Thibaut, the microscopists, he said, were liable to error just as the rest of us, but whenever they report cancer he would unhesitatingly advise operation. However, the picture of chronic endometritis and anedo-carcinoma differed in that in the former we never find three or four rows of epithelial cells forming a glandular appearance which obtains in the latter.

Communication.

Anthrax Measures in Louisiana.

Editors New Orleans Medical and Surgical Journal:

Gentlemen—It seems to me that the time is more than ripe for the medical profession to seriously consider and adopt some specific action looking to the amelioration of conditions brought about by the outbreaks of anthrax in animals, which occur from year to year in certain sections of our state, and more particularly those in which the infection has existed for how long, no one seems to have any accurate knowledge.

Apart from the economic importance of anthrax, in its relation to the live stock interests of Louisiana, which I will leave out of consideration here, there is the grave phase of the subject, viz: its transmissibility to the human subject by inoculation, and the possibility, through contaminated flesh, of a lurking danger in the local meat supply, which should appeal, with considerable force, to the profession who are the trusted conservers of the public health.

I have no doubt the great majority of members of the profession are aware that almost every year there are human victims to this fell scourge in the charbon-infected sections; and yet, so far, nothing has been done by the state to endeavor to intelligently control or eradicate the infection.

Only the other day (July 2d) I received a communication from Dr. R. W. Seay, of Grand Isle, La., saying he was reliably informed that recently about 27 cattle, suspected of charbon, had died at Cheniere Caminada, and that *the dead bodies had been left on the land or on the beach unburied.* On July 9th, another letter was received from Dr. Seay to the effect that the disease had spread to Grand Isle, two horses being reported infected, and that he had one *man* with the disease. (Italics are my own.)

This is only an example of what happens almost every year, when anthrax prevails; and I believe that the records of the Charity Hospital could bear me out to some extent, at least, in this statement.

It occurs to me that when human life is at stake in this manner, something ought to be done by the public health authorities to try to place a check upon the source, for the protection of our citizens. In fact, it seems little short of a serious reflection upon our vaunted ideas of sanitary progress, that, notwithstanding the length of time charbon has been known to exist in the alluvial sections of our state, with its numerous human victims, no measures have been taken by our health authorities to endeavor to eradicate the infection, and thereby minimize its baneful effects, so far as the human being is concerned.

Up to the present the control (?) of anthrax infection has been left solely in the hands of the lay stockowner, who has been permitted to do, or not to do, just as he pleased, with the result that the disease has been allowed to spread, with its fatal consequences, from year to year, without let or hindrance.

Now, gentlemen, this is not as it ought to be in a state which is so widely known for its achievements in medical sanitary science.

How to proceed in the matter in order to obtain relief I am not now prepared to say. But a bill has twice been prepared, emanating from a lay source, however, for the purpose of securing live stock sanitary legislation through our General Assembly.

When presented during the session of 1902, it passed its first reading in the House, being favorably reported upon by the Health and Quarantine Committee of that chamber, but was killed by an agricultural committee of the Senate. During the subsequent session of the Legislature, when it became known that it was the intention of those in charge of the measure to again present this, or a similar bill, they were informed that, if they did so, it would meet a similar fate to its previous experience; and this, notwithstanding the fact that the bill emanated from the State Board of Agriculture, or, at all events, the Commissioner, who is its executive officer. I mention these details to show that an effort has been made, but, at the same time, to emphasize the belief that it is evidently out of the question to expect any relief whatever from the Legislature, even in connection with such a vitally important matter, so long as the request is made or backed up only by lay sources or individuals. But, as is the case in some other states, the sanitary control of diseases of animals which are communicable to the human subject is frequently vested, by law, in their state boards of health, and which have, as a member of the board, an educated and thoroughly competent member of the veterinary profession to carry out the necessary sanitary provisions, so far as the animal source of infection is concerned. This is the case in Pennsylvania, Minnesota and other states of the Union.

If, then, the state is to obtain any substantial relief in the near future, at least, from the scandalously insanitary conditions which at present prevail in connection with anthrax infection, I am forcibly inclined to the opinion that it will have to come through the united influence of the medical profession in general, and of the State Board of Health in particular.

And, after all, when human life is so exposed it seems that such control ought, in reality, be placed under the operation of the state health authorities.

This is, indeed, gentlemen, a matter worthy the most serious consideration of our medical sanitarians, and ought not to be thoughtlessly set aside as of apparently minor import. Fortunately, the day of extensive epidemics of anthrax, such as those which occurred even as late as the last century, when some thousands of people died in some of the European countries from eating the unsterilized flesh of anthrax carcasses, seem to be at an end. Still, the disease continues to claim its human victims, and that, too, in our own state.

I must apologize for the length of this communication, but, having the honor, myself, of being a member of both the American Association of Public Health, and of the Royal Institute of Public Health, England, I feel that I would be recreant to duty did I not bring the question up for consideration by the medical profession of the state, in the interest of the public health of the state.

Very respectfully,
W. H. DALRYMPLE, M. R. C. V. S.
Louisiana State University, Baton Rouge, July 15, 1905.

REPORT IMMEDIATELY ALL CASES EVEN SLIGHTLY SUSPICIOUS AND SEE THAT THEY ARE PROTECTED AGAINST MOSQUITOES AT ONCE.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

Yellow Fever Situation.

Shortly after the middle of July it became known that New Orleans had become infected with the yellow scourge, imported, in the opinion of the State Board of Health, from Belize. The city health officials inaugurated a campaign of sanitation, chiefly of mosquito destruction, and organized a screened emergency hospital. It is very likely that these measures would have been successful had they been directed against the primary foci as was thought. Unfortunately, the Sicilians, among whom the disease practically was confined, had already become alarmed and had scattered, thus multiplying the secondary foci. Notwithstanding the prompt organization of auxiliary bodies by the people of New Orleans, who energetically came to the assistance of the health authorities, it was soon realized that we were facing a serious situation.

For various reasons, into which we need not enter at present, it was decided to appeal to the Government, and the Public Health and Marine Hospital Service was given control, with Surgeon J. H. White in command, the city and state agreeing to pay for labor and material, the volunteer organization continuing to give assistance.

The Public Health Service has continued the fight on the same lines, gradually perfecting its organization. As we go to press, the situation seems encouraging. We do not want to be too sanguine and believe that an accurate prognostication can be made only after the first week of September, but a comparison of figures with 1878 tends to give us a good deal of hope and to make us feel that, even if the disease may not be completely eradicated before frost, it will at least be held in check, be limited, and its mortality notably lessened.

We compare with 1878 because the disease began as early this year and was at first as virulent as in that fateful year. Taking the period up to the tenth of August, during which the disease had time to develop and before repressive measures could be expected to show any effect, we find that in 1878 it gave a total of 446 cases and 126 deaths, while in 1905 it totals 747 cases and 124 deaths; in other words, the fatalities are the same with more cases this year, probably because better reported.

If now we take up the second ten days of last month, or after we could look for results from warfare on mosquitoes, we find that during that period there occurred (officially) 889 additional cases in 1878, while in 1905, notwithstanding a perhaps even more careful search and report of cases than in the previous decade, there were recorded only 638 additional cases. The number of deaths speaks even more eloquently, for, in 1878, from August 10 to 20, there were **270** deaths, and in 1905, during the same period and time there were only **72.***

We must gird up our loins, brethren, and fight from now on even a better fight if possible. We must give loyal support to the Public Health Service and its representatives. Cases the least suspicious must be reported immediately and kept protected by mosquito bars until they can receive further attention. Do not discuss what might have been done or who may be to blame, at least for the present, but present a solid front to the enemy. Do what the JOURNAL has been urging you to do for the last few years, have fever patients screened and have the mosquitoes destroyed.

This is the time for the most strenuous and heroic effort of our lives. We feel that you will make it.

Pharmacology and Therapeutics of To-day.

A considerable revolution is in progress among medical periodicals, pharmaceutical factories and the organized medical profession. A survey of the medical journal utterances anent the new drug commission of the A. M. A., and the opinions of some of the manufacturers' inspired organs, show this very plainly. We published an editorial notice of this movement in the A. M. A., and were content to make little comment because, first, the ostensible

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*As we go to press we can furnish figures for five days more, including August 25. In 1878, there were for those days 674 additional cases; in 1905, there were **280**; deaths during the same five days, in 1878 were 213, in 1905, **36.**

motive was praiseworthy, and second, because the subject was entirely too recent to allow any critical opinion. Even now, the whole matter is not crystalized, as the first report of the commission is not yet published. The disturbance created by the initiatory operations of that committee, however, demand some commentary. We are pleased to direct this at first principles.

The lay public has, for a long time, regarded the dictum of the medical man as authoritative, and even if an occasional cavil arises, it is individual, and not general. Indirectly, the profession itself is responsible for the abuse of the general public by proprietary and patent medicine concerns. Any druggist will corroborate the statement that the bulk of his stock of proprietary medicines is kept for the physician's prescriptions, rather than for dispensing to the demands of ordinary counter trade. The neglected shelves of most doctors' offices are full of an assortment of these things, and if the public were not first reached through the medical profession, a regular staff of detail men would not be employed and salaried. When even the highest medical office in the gift of the profession is employed to exploit a proprietary medicine, even if a mild apology did follow, it argues the value the manufacturer places upon such endorsement. And the evil grows. Every one of these compound proprietary preparations carries reports in abstract or out-and-out endorsements, signed by the physicians themselves, often men of recognized authority in their own communities. Of course, the encouragement to further traffic in the medical man's gullibility follows.

These are the conditions as they exist. It requires only a short step for the remedy, accepted by the physician, to be popularized.

The essential factor in all this is much more radical. The fault lies in the training of the medical man himself. It is not far from the mark to say that nine-tenths of the graduates in medicine know little or nothing of pharmacology. Prescription writing is acquired slowly after practice is begun, and the vast majority of young doctors copy prescriptions of older men, or follow those printed in the texts.

The struggle of the medical student, after his degree, discounts all interest he may have in acquiring any of the elements of a medical education not required in the curriculum. Most medical schools either openly omit all teaching of pharmacy and pharmacology, or else devote a casual lecture or two to expounding the elements. The United States Pharmacopeia is practically unknown to the average medical student and physician, and original prescription writing is as lost an art as Damascene blades.

Healthy reaction has taken place in some of the lay periodicals, and this leaven may work out a good result, but cardinal readjustment of elemental teaching in medical schools must be brought about to insure even an intelligent co-operation in the medical profession itself. Demand for brain-saving expedients creates the supply of ready-made medicines, and so long as these are encouraged the supply will grow, and even with the highest purpose in investigation, no effect will be produced upon the rank and file of the profession until an educational process eventuates.

Post-Graduate Work at Home and Abroad.

We publish an article from Vienna which rather clearly describes methods for instruction practiced there, and which attributes the system to the American demand for regular work. Post-graduate schools, as such, are strictly American institutions, and in New York, Philadelphia, Chicago and New Orleans these have flourished for some twenty odd years. The American post-graduate school, however, is distinct in each of the centers where these exist. In New York the sole object attained is to multiply material and exponents of this and then allow the physician to have as much of either or both as he can pay for. Each division of medicine is taught by several different men, each, perhaps, having his own method. In Philadelphia, the classes are smaller and as a consequence much more attention is given to detail in methods of teaching. Chicago has, like New York, several schools for post-graduate teaching and in these much of the New York mode is followed, with the exception that here individual teachers are used as particular inducements, and these are made special features on the card. The New Orleans Polyclinic has always followed simple methods, proposing to furnish the post-graduate student with material for observation and a practical experience with the material at hand. In none of these schools is there any attempt made at original research. All simply try to supply a certain pabulum which the country doctor or the recent graduate demand in the shape of practical clinical teaching.

At Johns Hopkins, at Harvard, at Ann Harbor, in recent years, individual teachers, prominent in their particular fields, have encouraged special students, as graduates from other schools and others, to work with them in their research, but these have been comparatively few and the demand hardly large enough to establish what can be called a "school" at any of these institutions.

In Europe quite another aspect presents. In London several of the Hospitals have organized their staffs for the purpose of affording professional men the advantages of the material in these, and the demonstration is carried out for a nominal charge to the student. The School of Tropical Medicine under Manson's direction has already done notable work of world-wide importance. In Paris every hospital constantly affords the highest sort of opportunity to every man who will take it. Special and general hospitals each maintain a staff of the highest order. These men welcome students in their hospital and out door services, even in the laboratory under certain restrictions, and the regular attendance always profits the student.

The highest ideal of post-graduate study has not yet eventuated, but the Paris method certainly more nearly approaches this. Wherever the commercial equation enters, as in Vienna, in certain German clinics and in almost all the American, there is certain to be some loss in the general good. Where, however, the pride in good work and the sense of disseminating knowledge are the only recompense, the exchange is certainly along the Hippocratic lines and all are satisfied.

International arrangement for post-graduate study is yet unthought of—and most likely will be until standards are reciprocated, but we already have some things to teach, as we have many to learn, and while the hospital amplification is going on, the United States may yet reach an ethic plan of disseminating knowledge for knowledge sake.

Anthrax Prevention in Louisiana.

Attention has repeatedly been directed at the prevalence of charbon in the State of Louisiana, and that the disease grows more and more widespread. Elsewhere we publish a letter from Dr. Dalrymple, of the State University, again showing dereliction in the matter of protection. In spite of the lack of state legislation in this matter, it would seem to us that the police power of the State Board of Health would authorize its interference in this matter, if for no other reason, the even occasional infection and horrible issue in the human subject, of this disease, would demand that which, in the experience of other states, brings about a natural prevention or annihilation of this disease.

A Benedict.

The JOURNAL announces to its friends the marriage of one of its editors, Dr. Isadore Dyer, to Miss Mercedes Louise Percival. It took place at the St. Charles Hotel on Monday, July 31, 1905, the attendance being limited to the immediate members of the families. Dr. and Mrs. Dyer left on the same day for a trip North.

The remainder of the staff extend their warm congratulations and good wishes, in which, we are sure, our readers will join.

Dr. J. H. White.

New Orleans has been fortunate in the assignment of Dr. J. H. White to the command of the forces of the Public Health Service fighting the fever in this city. Experienced, though young enough to be active, intelligent as well as skilled, courteous yet firm, he has the esteem and co-operation of the profession.

We are grateful to Surgeon General Wyman for having sent him to us.

Personal.

Dr. Juan Guiteras, who is here as representative of the Cuban Superior Board of Health, is Professor of Tropical Diseases and of Pathology in the University of Havana. He has just been made Dean of that University. Our congratulations.

Prof. Rupert Boyce, President of the Liverpool School of Tropical Medicine, is here to study the prevalent disease. He is very welcome.

Abstracts, Extracts and Miscellany.

Department of Surgery

In charge of Dr. F. W. **Parham**, assisted by Dr. F. **Larue**, New Orleans.

Surgical Treatment of Hepatic Cirrhosis.—Mr. Delagniere, *Tribune-Médicale,* June 17, 1905, cites thirteen observations of various forms of cirrhosis, treated by cholecystostomy, combined with hepatopexy in two cases.

Better results are obtained in the hypertrophic cirrhosis than in the atrophic variety.

Temporary cholecystomy is more beneficial than omentopexy, and all other operations; a case of hypertrophic cirrhosis thus treated lived five years, and a case of mixed cirrhosis four years.

The results are still more marked when hepatopexy is combined with temporary cholecystostomy (eight years' survival in one case); finally it seems that the best results follow the combined treatment by hepatopexy, omentopexy and cholecystosomy; one case of atrophic cirrhosis is still alive, four years after this procedure.

Distant Post Operative Results After Talma's Operation.—Mr. Clément, *La Tribune Médicale,* June 17, 1905, states that much has been written about Talma's operation, but seldom is mention made of the autopsies on patients so treated.

Mr. Clément recently presented to the Société Anatomique, specimens from a case of alcoholic cirrhosis, in which Mr. Mouchet had three months previously performed an omentopexy (interposition of a large omental area between the parietal peritoneum and the transversalis fascia). At the site of the omentopexy, there were found distinct venous branches, crossing from the omentum into the muscle of the abdominal wall. Furthermore, a transparent view of the peritoneum revealed a number of vascular ramifications, emanating from the included omentum and united to the capillary veins of the anterior abdominal parietes. Elsewhere there were solid adhesions between the gut and the parietal peritoneum.

Department of Obstetrics and Gynecology.

In charge of DR. P. MICHINARD, assisted by DR. C. J. MILLER, New Orleans

THE STATUS OF PERFORATION OF THE LIVING CHILD AS AN AID TO LABOR.—Rudolph Katz (*Monatsschr. für Geb. u. Gyn.*) defends perforation of the living child in difficult labors, as it has been made use of in the Maternity Hospital of Mannheim. Veil has stated that every case that might lead to the necessity for operation, should be taken to a good hospital and treated by symphyseotomy or Cesarian section, so as to obtain a living child. The author contends that there are cases in which it is impossible to avoid doing a perforation. Such cases are those in which the patient has been under the care of a midwife, or a physician, for many hours, in which many examinations have been made with unclean hands, fever has set in, or the bladder, or uterus has been injured in attempts at delivery. Such cases are very unfavorable for operation of any kind, and perforation is the most rapid, and promises the best results. In many cases there is a probability that the child would not live, even if successfully delivered by Cesarian section. The mortality from Cesarian section would be nil, were all cases operated on when the patient is free from fever, and in good general condition. But such is far from being the case in the service of a maternity hospital. The statistics of the Maternity of Mannheim give these results: Of 6,935 cases delivered, 26 perforations, 0.37 per cent.; mortality of mother, 7.69 per cent; living child obtained in 63 per cent.

The mortality for Cesarian section for the last ten years was 10 per cent. This shows the mortality of perforation to be less than that of Cesarian section. That of symphyseotomy has been given also at 10 per cent. Symphyseotomy also has the disadvantages of being far from free from danger, having a long convalescence, and being liable to cause impaired bladder functions. Another element that has to be considered is the prejudice among the public, and physicians, against Cesarian section. Many women who are brought to a hospital refuse, absolutely, to submit to a section. They cannot be turned away, and something must be done to deliver them. The indications that were considered to justify perforation, in the 26 cases that were operated on in this way in the maternity, were: Rise of temperature, bad general condition of the mother, eclampsia, threatened rupture of the uterus. Of the 26 cases, narrowed pelvis existed in all. If the pelvis is so contracted that delivery is impossible, the patient and physician think only of Cesarian section; if the deformity is less, they attempt delivery by other means, and often the patient is reduced to a low condition before she will submit to radical interference. Hence, the author concludes that it is the duty of obstetricians to popularize as much as possible, the idea of Cesarian section as the best method of securing a living child, but that there will still remain many cases that must be delivered by perforation, on account of the impracticability of using other means.—*Amer Jour. Obst.,* June, 1905.

Department of General Medicine.

In charge of Dr. E. M. Dupaquier, New Orleans.

Modern Conception of Bright's Disease. (Crafton, in *Jour. A. M. A.,* June 24, 1905).—The determining feature of Bright's disease is high arterial tension, with resulting cardeovascular changes. The latter lead to nutritional disorders in various parts of the body, and particularly in those organs that are supplied by end-arteries, viz., the kidneys, retina and brain.

The old idea that in Bright's disease the kidneys are always primarily involved, and that as a result of renal inadequacy, certain toxic products are retained that produce the cardeovascular changes, and the eye and the brain symptoms is untenable, for many cases of Bright's disease occur in which the kidneys are not involved until very late in the course of the disease, long after cardiac hypertrophy, retinitis, albuminuria and brain symptoms have appeared. True, there are many infections and intoxications of an acute character, in which the kidneys are primarily affected. Most of these, nephritides, however, run their course without any involvement of the heart, the arteries, the retina or the brain. If, occasionally, late in their course, degenerative changes about the heart and arteries, as well as in many other organs of the body, occur, then these secondary events must be considered due to the general toxemia, that is, to the inevitable result of advanced degrees of renal insufficiency. These, however, are not cases of Bright's disease. The underlying causes, and above all, the sequence of events are different. It is unfortunate that the name Bright's disease is retained at all in our medical nomenclature, for what we understand by this term, and what Richard Bright originally described are two very different things. It is still more unfortunate that the terms Bright's disease and nephritis are so commonly employed *synonymously*. This is radically wrong, for Bright's disease, in the modern sense, is a systemic disorder that usually produces nephritis, but does not invariably do so, and nephritis, while often due to Bright's disease, may also be due to a great many other causes. It is not tautology, therefore, by any means, to speak of the *nephritis of Bright's disease.*

RACE SUICIDE.—From the *American Therapist,* April, 1905, we gather the following: The lay press has teemed with references to race suicide lately, interest in the subject being largely due to repeatedly expounding its dangers, in and out of season. Women who do not, or will not, bear children, are held up to scorn. To be married and without children is to be considered a crime before man, God, and one's country, and all this blame is laid at the wife's door; the husband is a much sinned against individual, etc* * * We protest against all this amateurish philosophy. What does the layman know of the possibilities of motherhood, or of all that it entails? Because one family chooses to, or can have a family of eight or more, are they in any respect superior to those of three or four? Let us have done with this ranting, this "much ado about nothing."

That the birth rate is diminishing in highly civilized countries, is probably true; but is this the forerunner of the extinction of the human race? Is not this as it should be? Has not civilization entailed upon us this difference from the animal or the savage? Is it not true that the parent of today has a higher moral or parental instinct than all this talk would indicate? Is he not morally superior to the past generations? Does he not realize the responsibilities of bringing into the world children who are left to shift for themselves? Is he not more concerned in the future welfare of his children than to deprive them of advantages which they certainly would not have if there were more to educate, clothe and care for, than a moderate income will provide? Is it not his proper aim to bring into the world well-born and well-bred children, and not those who fill our orphan asylums, charitable institutions, jails and reformatories? Is it not right that every child brought into the world should have the right of proper bringing up, and an equipment for his life's work? Life should have higher aims than an ungoverned desire to add to the population of the world.

The higher the development of the race, the lower will be the birth rate. The danger to be apprehended is not that the world will be depopulated, but overpopulated. Take India, China and Russia, where parental responsibility does not prevail, and contrast their teeming hordes and the inevitable famine, pestilence, etc., with conditions which do not prevail in highly developed countries or communities. Because of improved sanitary conditions in these latter countries, the death rate is enormously less than formerly. But, even with famines and pestilences, the population of India is not materially decreased, for the enormous birth rate is maintained, no matter if there is lack of food, comforts and other necessities to a nobler life. Let us view the subject of race suicide from a philanthropical and humane standpoint.

Department of Nervous and Mental Diseases.

In Charge of **Dr. P. E. Archinard** and **Dr. Roy M. Van Wart**,
New Orleans.

Codeinism—Pelz (*Deutsche med. Wochenschr.* June 1, 1905), publishes the first case of what he considers true codeinism in literature. The patient was a degenerate individual of 26, who had inherited constitutional depression and after an attempt at suicide was given a prescription for codein pills by a physician. The relief he experienced on taking the remedy impelled him to consume larger amounts, and a marked habituation rapidly developed until, as he alleged, he consumed 70 to 100 pills a day. Attempts to dispense with the drug resulted in restlessness, irritability, loss of energy, an intense longing for it, and finally even large doses did not produce the desired effect, and he resorted to other narcotics, though only to a slight extent. The treatment consisted of an immediate withdrawal of the codein, and oniy a few doses of other sedatives were given. At first the abstinence was severe, and included insomnia, vomiting, and diarrhoea, but in about two weeks most of the complaints had ceased, and after that the patient made steady progress. The author believes that greater care should be taken in prescribing narcotics to those physically weak, as this man was, and he considers that it was this mental defect which made it possible for a codein habit to be developed.

BASEDOW'S DISEASE.—*Jellinck* (*Wien. Klin. Wochensch.* No. 43, 1904), describes a symptom not formerly observed. It consists of a brown, equally distributed and diffuse pigmentation of both eyelids, chiefly in the upper. It is bounded by the eyebrows above and the infraorbital margin below. There was no involvement of the conjunctiva. It belongs to the early symptoms. The pigmentation in many cases tended to disappear later in the disease. In several it was altogether absent.

Department of Therapeutics.

In Charge of DR. J. A. STORCK, New Orleans.

IODIN TREATMENT OF TYPHOID.—Ceriolo states that typhoid is endemic where he lives, and his cases were always severe, the fever persisting high. One patient succumbed to pulmonary complications. Since he has begun to use iodin systematically in treatment, his cases have all been mild. Even when the onset was stormy, the disease rapidly assumed a mild course. He administered 7 cg. of iodin and 70 cg. of potassium iodid during the day, fractioned, with a quantity of water. He gave also from 15 to 20 cg. of quinin to retard the tissue breakdown, and 50 cg. of sodium benzoate, to favor elimination of waste.

MEDICAL TREATMENT OF INGROWING NAIL.—Gasparini has found that copious applications of dried powdered alum is sufficient to cure every case of ingrowing nail in his experience in about five days. The applications were never painful in the least, and the destruction of the pathologic tissue resulted in the formation of a hard, resistant and non-sensitive bed for the nail, a perfect cure for the ingrowing tendency. The non-toxicity of the alum.

its easy application and the fine results render it the chosen treatment for cases in which surgical intervention is not contemplated. He describes a series of cases, and contrasts them with another series treated with other caustics, with far less favorable and durable results. He applies a fomentation of soap and water for 24 hours beforehand, and then pours the alum into the space between the nail and its bed, tamponing with cotton to keep the alum in place, and repeating the application daily. The suppuration rapidly dries up and pain and discomfort are relieved almost at once. —*Gazetta degli Ospedali, Milan.—Jour. A. M. A.*

TYPHOID FEVER TREATED WITH OIL OF CINNAMON.—One hundred and forty-seven cases of typhoid fever were treated by this means with a mortality of 9.5 per cent. Oil of cinnamon, especially when given at the beginning of the disease, lowers temperature and produces a tendency to sleep, which diminishes the likelihood of delirium. It has bees proven that intestinal fermentation, manifested by abdominal pain, tympanites and fetor of the stools, are diminished by this drug. The cinnamon oil acts as an antiseptic and hypnotic in cases of typhoid. The best method of administration is to give 3 to 5 drops every two hours from the beginning of the disease until the fall of temperature.—*Mercks Archives.*

ACUTE PRURITUS.—Gaucher recommends that patients suffering from acute pruritus shall be placed on a strictly milk diet at first and later a milk-vegetable diet. To calm the itching he recommends acetic acid lotions, followed by ointments of menthol and guaiacol.

N. B.—In all cases of pruritus, careful examination should be made for fissures or abrasions, which, as a rule, require surgical treatment.—J. A. S.)

If there is extreme irritability, an injection of morphine will be beneficial, but should be used with caution.

As an accessory treatment, fresh air, moderate exercise and a mild climate in winter are useful. During the summer, the seaside will be of benefit to some.

The diet must be strict, no raw fruit, acid vegetables, rhubarb, tomatoes or salad, no coffee, tea or wine. Beef and red meats generally are prohibited. Only milk, cocoa, vegetables, eggs and white meats are allowed.—*American Medicine.*

Louisiana State Medical Society Notes.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr. J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First St., New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist., Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. District, Sunset.

In charge of DR. P. L. THIBAUT, Secretary, 141 Elk Place.

(*Continued from July and August Numbers.*)

THE CHAIRMAN OF THE COUNCIL, DR. A. G. FRIEDRICHS, made a verbal report on the status of the various Congressional Districts and Parish Societies therein.

In closing: I want to say that, from my experience in organization work, we have now gotten to a point where our association ceases to be an experiment, and I believe that anything we ask, we can receive. If we still act in unison and abandon any selfish motives, we can get any relief which we are now in need of. We have an organization in every Parish in this State but twelve, and you will readily appreciate what an influence this will give us if we unite our efforts in one direction.

I think the time for action has come. Let us go out to the firing line.

I would suggest that whatever we want in the matter of relief, we place before the Committee on Legislation, and then every Parish Society in the State ought to organize a Committee on Legislation, and then all act together, in unison, for the one purpose, and I think that we will be bound to get the legislation that we want.

There is no use for us to stand around and complain.

If we would go into this business in an active sort of way we would get these things that we need.

There is not a thing that any politician in the State could deny us.

I am sure that the influence of the physician is very great. He is consulted about everything, moral, physical and financial. There is not a particle of doubt about this. No one need tell me we cannot get whatever we want, if we go after it in a sensible, systematic and businesslike way.

At the last Legislature it was suggested that if we did not make some concessions we could not get our legislation through.

We have the power and the influence, and if we only have the sense, we can put through any legislation that we may ask for.

The Secretary of the Council, Dr. J. J. Ayo, then read his report.

Gentlemen: I beg to submit the following report upon the standing of the medical profession in the Third Congressional District of Louisiana. I believe I have a fairly correct list of the physicians in the eight parishes comprising this district.

Total number of white registered physicians	147
Total number of colored registered physicians	7
Total number of registered physicians	154
Total number not having diploma	3

Out of this total of 147 white registered physicians 69 belong to parish associations and are therefore members of this Society.

The eight Parishes comprising this district, Assumption, Lafourche, Terrebonne, Iberia and Vermillion are pretty well organized. St. Mary and Lafayette have been organized but are not active. St. Martin has no organization.

Respectfully submitted,

J. J. Ayo, M.D.
Councillor for Third District.

Report of the Councillor First Congressional District.—When this report was called for, Dr. A. G. Friedrichs stated that there was practically no report to offer from this district, as the matter was included in his report as Chairman.

The Report of the Councillor of the Fourth Congressional District, Dr. N. K. Vance, Chairman, was then read.

To the Members of the Louisiana State Medical Society.

Gentlemen: It is with great pleasure and much gratification that I submit a report from the Fourth District. In our district the profession has met the organization movement in a most commendable spirit. In all localities an interest is manifested, and, in some, a positive enthusiasm prevails. This is proved by the fact that with nine parishes in the district, we have eight chartered societies. Seven of the parishes, viz.: Bienville, Bossier, Caddo, De Soto, Sabine, Webster and Winn, have individual parish societies, and two, Natchitoches and Red River, have formed a bi-parish society—this was done on account of the small number—about ten—of practitioners in Red River Parish. In most of the parishes, I believe, about two-thirds of the eligible men are now in the societies, and in another two years, I hope to see fully nine-tenths of them in. In some parishes, conditions were decidedly discouraging, owing to long distances, bad roads, failures in similar attempts before, etc. But now we have a good foundation laid in every Parish, and if those who have already gone into the movement, are imbued with the proper spirit, and I believe they are, they can and will succeed.

It will require some work to arouse all to an appreciation of the benefits—social and professional—to be derived from parish societies, but the spirit of Aesculapius will finally light upon them, and they will "come through" all right. I have found some little friction here and there, as you will always find, where twelve or more doctors are gathered together, but there is every evidence to show that this condition will be ignored, where parish societies are acknowledged successes. The detailed report which I now present, is as nearly accurate as is possible for me to offer you:

Parishes.	**With Diplomas.**	**Without Diplomas**	**Homeopaths.**
Bienville	27, registered	3, registered	1, registered.
Bossier.	25, 2 not reg'std..		1, registered.
Caddo (white) 67, colored 6).	73, 3 not regis'td.	2 registered	
DeSoto	26, registered	2, not registered.	
Natchitoches	30, 4 not regis'td.	4 registered	
Red River	10, 1 not reg'std.	3, not registered..	
Sabine	27, 3 not reg'std..	9, registered.	
Webster	14, 3 not reg'std..		
Winn	14, 2 not reg'std..		

In the City of Shreveport we have 37 white physicians, including 1 homeopath—29 are members of our Parish Society. Two others made application at our last meeting—this will make 31 out of 36, eliminating one homeopath. In a town as large as Shreveport we, of course, expect to find irregulars of almost every breed, and so it is. We have osteopaths, magnetic healers, Indian doctors, a corn doctor, etc.

So far as deaths are concerned we have been exceedingly fortunate. It is with genuine sorrow that I make mention of the death of Dr. H. C. Coty of our city. Dr. Coty was a member of our State and Parish societies. He was an excellent physician, an estimable citizen and was greatly beloved by his clientele.

The figures given above, foot up a total of 246 graduates in practice in our district, of whom 18 are not registered for some cause; we also have 23 practicing without diplomas, of whom 5 are not registered; and 2 homeopaths both registered. In addition to the irregularities mentioned above, a number of undergraduates come into the country districts every spring and practice until lectures are resumed in the fall. Several practitioners have complained of this latter condition, but there is absolutely no remedy at hand. The present law regulating the practice of medicine, etc., is a perfect absurdity, and I fervently trust the matter will be discussed by this Society at this meeting, and that the McGehee Bill, or some similar one, will be indorsed, and every possible influence be brought to bear to secure its enactment. The country parishes are now thoroughly appreciative of the importance—yes, necessity, of such a law Interest is at a high pitch, and it can be safely predicted that such a measure, emanating from this Society, will receive more effective support from the country than at any former time. This will be done by a direct, personal appeal to the representatives from the various parishes, for the passage of the Bill. Let us get together. With a "long pull, a strong pull, and a pull altogether," we can secure the legislation that we ask for.

Respectfully submitted,

N. K. VANCE,
Councillor Fourth District.

THE REPORT OF THE COUNCILLOR FOR THE FIFTH CONGRESSIONAL DISTRICT, DR. S. L. WILLIAMS, Chairman, was then read by the Secretary.

First—Work in organizing the medical profession in this district began first in Richland Parish; this parish getting the first charter from the State Society under the new Constitution, through the efforts and influence of Dr. Barrier, then State President, and one whom the entire State applauded.

The Richland Parish Medical Society is a thrifty one at present, with Dr. H. B. Wren, President, and Dr. D. R. Sartor, Vice President.

Drs. Whelis, Jordan and Noble have left the Parish. Dr. Rogers Hays is practicing near Alto; Dr. A. T. Evans is located at Rayville, La. There are fourteen regular physicians, one man without a diploma.

Second—The Morehouse Parish Medical Society has celebrated its first anniversary under the new Constitution, having had a long life previous, with a respectable list of ex-officios, whose untiring devotion kept the profession organized quite as well as the New Orleans Medical Society. The present officers are: Dr. Vaughan, President; Dr. Hunter, Vice President, and Dr. Patterson, Secretary and Treasurer; backed by a membership of fifteen up-to-date M. D.'s. Only one non-graduate (Dr. Ben H. Brodnax). One before the State Board of Examiners (Dr. F. V. Jordon). Dr. A. J. Thomas' application pending.

Drs. Drusback, Russell Pricket and James Hope, non-members of the Society.

Dr. H. A. Gantt has removed to Mexico.

Society meets monthly.

Third—Ouachita Parish Medical Society is next on the list, having as President Dr. Miller, as Vice President Dr. Pugh, and as Secretary Dr. O'Donnell. This Society is in position to be one of the leading in the district, having within its scope 23 physicians, Of this number 20 could belong to the Society; 3 have retired, but could be honorary members; these are Drs. Sandle, Keys and Hines. Dr. I. J. Newton, of Little Rock, has again opened an office in Monroe. There is one negro physician, registered and practicing.

Fourth—Lincoln Parish Medical Society has a chartered membership with good support, and means to run rival with her sister parishes. Officers are Dr. Howell, President; Dr. Cook, Vice President; Dr. W. L. Kendell, Secretary-Treasurer. Monthly meetings regular. There are seventeen regular physicians. Those without diplomas, as reported by the official journal, are hard to find. Only two regulars not members of Society.

Fifth—Franklin Parish Medical Society is quite active and progressive. The officers are: Dr. Griffin, President; Ramage, Vice President, and Guice, Secretary. There are twelve regular physicians practicing, one without diploma.

Sixth—Claiborne Parish Medical Society has elected officers for 1905 as follows: Dr. Jerrell, President; Dr. Walter, Vice President; Dr. Knighton, Secretary-Treasurer, of Homer, who has served faithfully and efficiently for the general good of the profession. The membership and attendance are good; with eighteen practicing physicians, nearly all are members of the Society.

Seventh—Catahoula Parish Medical Society was organized and chartered this year with Dr. Pugh, President; Dr. Halloman, Vice President, and Dr. C. H. Burley, Secretary-Treasurer. The latter is an especially energetic man in his work. Drs. Holstein, Madden, Coney, are charter members. There are 18 widely scattered regulars; at least two without diplomas.

Eighth—Concordia Parish Medical Society was chartered April 3, 1905, with six charter members. Dr. D. H. Trepagnier, President; Dr. S. W. Scott, Vice President; Dr. J. T. Reeves, Secretary-Treasurer. This Parish was organized by Dr. Chassaignac, to whom we extend thanks for efforts put forth in the organization. There are eight physicians in the Parish.

Ninth—Tensas Parish Medical Society at a meeting on April 3, 1905, elected the following officers: Dr. Bellinger, President; Dr. Murdoch, Vice President; Dr. E. D. Newell, Secretary-Treasurer. This Parish has a membership of 12; all are registered.

Drs. Marable, Strecker and Purnell have moved from the Parish.

Tenth—Union Parish Medical Society is chartered, but has not elected officers for this year, but is surrounded with material and will no doubt add a membership to the list. There are 15 regular physicians. Dr. A. J. Thomas has removed to Mer Rouge. There remain three without diplomas.

Eleventh and Twelfth—Madison and Jackson Parishes are partially organized; Jackson more so than Madison, as several attended a call meeting last month, but were unable to elect officers owing to small attendance. The number to organize is nine.

Madison Parish physicians were notified to attend a call meeting on March 29, but for various reasons were not in attendance. There are 12 regular M.D.'s. These parishes are open to accepting charters as the interest is aroused.

Thirteenth—Caldwell Parish Medical Society held a meeting on May 2, and united for the second time to elect officers and apply for a charter. This will be granted as soon as the Secretary can get the signatures of the officers. There are 8 regulars and 1 without a diploma. Dr. W. P. Hough is dead.

Fourteenth and Fifteenth—East and West Carroll are not organized for lack of members. The only hope will be in getting one Society between them. Seven physicians in East Carroll, and two in West Carroll; about three without diplomas.

Recapitulation—Fifteen Parishes; 11 organized societies; 10 chartered societies; 2 partially organized societies;2 unorganized societies; 185 practicing physicians; 9 without diplomas; 1 negro M.D.

Respectfully submitted,

SIDNEY L. WILLIAMS,
Councillor.

Oak Ridge, La., May 6, 1905.

(*To be continued.*)

Orleans Parish Medical Society Notes.

President, Dr. L G. LEBEUF. *Secretary*, Dr. ALLAN C. EUSTIS,
141 Elk Place.

It is with pleasure that we are able to announce that all bonds of the Society have been paid for in full. Interest on these bonds has also been paid on July 1st.

The Committee on Arrangements, of which Dr. Wm. M. Perkins was the efficient chairman, conducted their affairs on such a sound financial basis that they were able to purchase six bonds from their surplus. These bonds have been presented to the Society and have been retired along with 12 other bonds drawn by lot by the Board of Directors. These facts speak better than anything else for the splendid financial condition of the Society, and the efficient services of our genial Treasurer.

Medical News Items.

THE FOLLOWING COMMISSIONED MEDICAL OFFICERS of the Public Health and Marine Hospital Service have been assigned for duty in this city and state: J. H. White, surgeon and in command; G. M. Guiteras, surgeon; past assistant surgeons: Robert Blue, J. B. Green, C. H. Lavinder, John McMullen, G. M. Corput, T. F. Richardson, D. H. Currie, T. D. Berry and R. H. von Ezdorf; assistant surgeons: W. C. Rucker, H. G. Ebert, F. C. Smith, E. M. Steeger, F. H. McKeon, E. A. Sweet, W. H. Frost and E. H. Mullen.

THE EMERGENCY HOSPITAL, which was organized by the City Health Board shortly after yellow fever was declared in New Orleans, and has been continued by the U. S. P. H. and M. H. S. since health matters were turned over to them, is situated in an old-fashioned three-story brick residence on Dumaine street, near the French Market, in the heart of the primarily infected district.

Considering the original deficiencies of the building and the haste with which the organizers had to work, a very creditable hospital arrangement has evolved. In addition to the Board of Health officials, great credit for the organization and for the excellent care which is received by the patients is due to the medical staff, which is composed as follows: Dr. Hamilton P. Jones, physician-in-chief; Drs. Chas. Faget and J. B. Guthrie, resident physicians; Dr. P. E. Archinard, pathologist; Dr. F. Formento, consultant; L. H. Marks, superintendent and interne; M. Thomas Lanaux, interne; R. T. Perkins, who has been assisting Dr. Guthrie.

The hospital has a capacity, if crowded, of 100 patients in eleven wards. Admissions up to August 22, at the time of our visit, numbered 160.

THE AMERICAN PUBLIC HEALTH ASSOCIATION has sent out preliminary announcement of its 23rd annual meeting to be held at Boston, Mass., September 25-29, 1905.

THE ANNUAL CONVENTION OF THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION will take place at the New York Academy of Medicine September 19, 20 and 21, 1905.

THE MASSACHUSETTS STATE BOARD OF CHARITY has purchased the island of Penikese, in Buzzard's Bay, and a leper hospital will be constructed there.

THE STATE EXAMINING BOARD OF THE ARKANSAS MEDICAL SOCIETY at its last meeting had thirty-one applicants and twenty-three passed.

A STATE SOCIETY FOR COLORED PHYSICIANS was organized in Virginia July 29.

THE OHIO STATE MEDICAL UNION is the name of a new society recently established in Columbus, Ohio. A legally qualified practitioner of medicine, of no matter what school of practice, is eligible to membership.

THE NEXT INTERNATIONAL MEDICAL CONGRESS will be held in Lisbon, April 19 to 26, 1906. It is expected that it will be one of unusual importance, for a meeting which will be held in what has always been considered an out of the way country. Already the titles of papers from some of the most distinguished men in the medical profession have been received.

THE AMERICAN MOSQUITO EXTERMINATION SOCIETY.—The Constitution and By-laws provide for seven classes of membership. An Active Member pays $2.00 annually. A Sustaining Member is an individual or organization contributing $5.00 annually. An Associate Member pays $10.00 a year; a Benefactor, $25.00 at one time; a Life Member, $100.00; a Patron, $500.00; and a Founder, $1,000.00. The work of the society for the past year has been to distribute all the literature published in 1903-1904. It is proposed for the year 1905 to issue a year book for 1904-5, containing the very interesting and important features of the Second Convention and other matter new to those joining, bringing the record of work up to date.

THE ST. LOUIS SKIN AND CANCER HOSPITAL.—On July 1 the St. Louis Skin and Cancer Hospital opened its doors for the reception of patients. This institution, situated on the southeast corner of Jefferson and St. Charles streets, consists of a completely equipped hospital of forty beds, and an out patient or dispensary service.

AT THE LAST MEETING OF THE TANGIPAHOA PARISH MEDICAL SOCIETY there were ten in attendance. This growing society meets quarterly, and the next meeting will be on October 11.

THE ASSUMPTION PARISH MEDICAL SOCIETY met in regular session on July 13. Dr. W. E. Kittredge, of Napoleonville, La., read a paper on "Acute Diarrhœa." Dr. A. A. Landry, of Paincourtville, opened the discussion, which was participated in by most of those present. The following resolution was unanimously adopted: "Be it resolved, That the expression, 'I cured the case,' if used at all, should be used with great moderation by the members of this society." The society then adjourned until October.

MARRIED.—DR. WILLIAM EHLERT and Miss Vashti Lanier, on July 12, at Covington, La.

DR. FREDERICK R. LOEBER and Miss Margaret E. Cox, at Trinity Chapel, July 27, 1905.

DR. PHILIP C. DEVERGES to Miss Nelvylle Marie Poupart, on August 29, at St. Theresa's Church.

DIED.—DR. T. P. VAUGHN died on August 11, aged 93 years. The doctor practiced in West Baton Rouge nearly seventy years.

DR. WILLIAM HUNTER CARSON, past assistant surgeon, U. S. Marine Hospital Service, died at Belize on July 25. The doctor was well known in New Orleans.

THE SEVENTEENTH ANNUAL MEETING of the Tri-State Society of Alabama, Georgia and Tennessee will be held in Chattanooga, Tuesday, Wednesday and Thursday, September 26, 27 and 28, 1905.

Book Reviews and Notices.

All new publications sent to the* Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.

A Practical Treatise on Fractures and Dislocations, by Lewis A. Stimson, B. A., M. D., LL. D. Lea Brothers & Co., New York and Philadelphia, 1905.

This is the fourth edition of Stimson's well-known book on fractures and dislocations. It appears in one volume, but is nevertheless a complete and exhaustive treatise on these two most important and practical subjects.

The most common and rarest fractures and dislocations are all mentioned, and made still more lucid by several fine illustrations and skiagrams.

This work will be most useful in the hands of the advanced student and busy practitioner, who will, by careful reading, cull some sound surgical (conservative) advice. Larue.

Pharmacology of the Fluid Extracts, by Dr. John S. Wright. Eli Lilly & Co., Indianapolis, 1905.

This is a handy, practical digest of the subject, arranged alphabetically and succinctly for the convenience of the student and physician.

"Maternitas," by Chas. E. Paddock, M. D. Cloyd J. Head & Co., Chicago.

This little book is one of the simplest and most sensible works of advice and assistance to mothers and to those who are about to give birth. The language is plain, simple, easily understood, and there is a fortunate absence of technical terms that many such books contain, and that women, as a rule, do not understand. It is brim-full of common sense.

Michinard.

Progressive Medicine.—A quarterly digest of advances, discoveries, and improvements in the medical and surgical sciences. Edited by Hobart Amory Hare, M. D., assisted by H. R. M. Landis, M. D. March, June and September, 1904. Lea Bros. & Co., Philadelphia and New York.

The contents of volume I are Surgery of the Head, Neck and Thorax, by Charles H. Frazier, M. D.; Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia and Influenza, by Robert B. Preble, M. D.; Diseases of Children, by Floyd M. Crandall, M. D.; Laryngology and Rhinology, by Charles P. Grayson, M. D.; Otology, by Robert L. Randolph, M. D., closing with the index.

The contents of Volume II. are Surgery of the Abdomen, Including Hernia, by William B. Coley, M. D.; Diseases of the Blood; Diathetic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland and Lymphatic System, by Alfred Stengel, M. D.; Ophthalmology, by Edward Jackson, M. D., and the usual index.

The contents of Volume III. are Diseases of the Thorax and its Viscera, Including the Heart, Lungs and Blood Vessels, by William Cuvart, M. D.; Dermatology and Syphilis, by William S. Gottheil, M. D.; Diseases of the Nervous System, by William G. Spiller, M. D.; Obstetrics, by Richard G. Norris, M. D., and the usual carefully made index. Dupaquier.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR JULY, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	28		28
Intermittent Fever (Malarial Cachexia)	10	1	11
Smallpox			
Measles			
Yellow Fever	42		42
Whooping Cough	3	1	4
Diphtheria and Croup	2	1	3
Influenza			
Cholera Nostras	1	1	2
Pyemia and Septicemia	3		3
Tuberculosis	44	40	84
Cancer	14	5	19
Rheumatism and Gout	2		2
Diabetes	2	2	4
Alcoholism	6		6
Encephalitis and Meningitis	12	2	14
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	11	3	14
Paralysis	2	2	4
Convulsions of Infants	1	2	3
Other Diseases of Infancy	12	3	15
Tetanus	3	6	9
Other Nervous Diseases	3		3
Heart Diseases	28	18	46
Bronchitis	4	3	7
Pneumonia and Broncho-Pneumonia	11	5	16
Other Respiratory Diseases	3	1	4
Ulcer of Stomach		1	1
Other Diseases of the Stomach	2		2
Diarrhea, Dysentery and Enteritis	37	16	53
Hernia, Intestinal Obstruction	3	2	5
Cirrhosis of Liver	4	1	5
Other Diseases of the Liver	3		3
Simple Peritonitis		1	1
Appendicitis	4		4
Bright's Disease	28	10	38
Other Genito-Urinary Diseases	2	5	7
Puerperal Diseases	3	2	5
Senile Debility	14	6	20
Suicide	7		7
Injuries	19	12	31
All Other Causes	15	9	24
TOTAL	389	161	550

Still-born Children—White, 20; colored, 13; total, 33.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 19.53; colored, 22.46; total, 20.30.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	29.99
Mean temperature	82.
Total precipitation	3.93 inches.

Prevailing direction of wind, southwest.

New Orleans
Medical and Surgical
Journal.

VOL. LVIII. OCTOBER, 1905. No. 4

Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a Written order for the same accompany the paper.)

Prostatism Without Prostatic Enlargement.

By G. FRANK LYDSTON, M. D.,

Professor of Genito-Urinary Surgery and Syphilology, State University
of Illinois; Attending Surgeon, St. Mary's and Samaritan Hospitals,
Chicago, Illinois.

One of the most troublesome conditions of the bladder that comes under the observation of the surgeon is that in which all of the symptoms of prostatism exist without any enlargement whatever of the prostate or tumor at the vesical neck. These cases, so far as I am aware, have not been carefully analyzed, although they have received attention here and there in the literature. The importance of the subject suggests itself to me with especial force, because of a statement which I recently heard made by a prominent operator in the field of genito-urinary diseases. This gentleman said: "In the absence of tabes, residual urine means an enlarged prostate." To this statement I take decided exception.

In considering the question of prostatism without prostatic enlargement or tumor at the vesical neck, I would advance the following fundamental propositions, viz.:

1. That obstruction at the vesical neck has precisely the same effect, whatever the cause of the obstruction may be.
2. That obstruction at the vesical neck does not necessarily mean prostatic enlargement or a tumor in this location.
3. That relative obstruction at the vesical neck, without overgrowth of the tissue, produces the same effect as does the latter condition.
4. That an overgrowth of tissue at the vesical neck often occurs where there is absolutely no neoplasm.
5. That a relative weakness of the bladder walls has precisely the same mechanical effect as a relative obstruction at the neck of the bladder; in fact, it is practically the same thing.

The functional capacity of the bladder revolves largely around a harmonious relation between the resistance of the vesical orifice, on the one hand, and the tone of the bladder muscle upon the other. It is well known that obstruction at the vesical neck impairs the vesical tone. It is also well known that tabes, paralysis of spinal origin, and prolonged retention from one cause or another produce, on the one hand, permanent atony or paralysis of the vesical muscles, and, on the other, temporary atony or paralysis.

We meet with a certain class of cases in which, as a consequence of prolonged irritation at the vesical neck, a certain amount of connective tissue hyperplasia and muscular hypertrophy affecting the internal sphincter occur. Before middle life there is sufficient reserve tone and elasticity of the bladder walls to compensate for what would otherwise be a loss of balance between the power of the bladder and the resistancy of the vesical neck. As the age of the patient increases, however, this reserve fund of tone and elasticity becomes exhausted, and the bladder becomes increasingly less powerful. The resulting loss of balance between the expulsive power of the bladder and the normal resistancy of the vesical neck enhances the senile lack of tone. After a time there is a definite accumulation of residual urine, which assists in compounding the pathologic conditions already present. It is in this class of cases that we find in prostatectomy a rigid internal sphincter, which is distinctly thickened from hypertrophy and hyperplasia, but without the slightest appearance of tumor. I have met with numerous cases in which the relative obstruction at the vesical neck was due primarily, not to any change in the tissues in that location, but to a congenitally defective bladder wall. In two of my recent cases a diagnosis of prostatic obstruction had been made by several surgeons, and a prostatectomy advised. I found, on examination, that no enlargement of the prostate existed. The cystoscope showed not only a complete absence of prostate and vesical tumors, but a degenerated bladder wall, with multiple sacculi of varying size. In another case of this kind the prostate was not only not enlarged, but was the normal senile prostate, *i. e.*, it was atrophied.

It will be readily understood that in cases of congenitally defective structure of the vesical wall producing a relative obstruction at the vesical neck, no symptoms are likely to manifest themselves before middle life, or beyond it. So long as such muscular and elastic tissues as exist in the defective bladder walls are sufficient in amount and sufficiently vigorous in tone to overcome the resistance offered by a normal vesical sphincter, no symptoms result. When, however, the resistancy of the internal sphincter is relatively increased because of the gradual weakening of tone of the vesical wall, symptoms begin to manifest themselves. As already stated, residual urine is soon discoverable and infection sooner or later occurs, either as a result of treatment, as is most frequently the case, or without it, as may happen.

Cystitis once developed, the relative obstruction at the vesical neck is made actual by inflammatory or hpyertrophic changes at the vesical orifice.

In a general way, it may be said that relative obstruction at the vesical neck is to a certain extent responsible for the phenomena presented in atony or complete paralysis of the bladder wall, in which the vesical sphincter is involved in the paralysis. The hyperdistension of the bladder and retention of the urine incidental to these neuropathic conditions do not occur where there is paralysis of the vesical sphincter, because of the incontinence and constant drainage, this latter condition being very much safer for the patient, despite its attendant discomforts, than retention. Independently of neuropathic conditions producing enervation of the vesical muscularis, the tone of the bladder may be impaired by acquired conditions affecting the structure of the muscular tunic. The prolonged retention occurring in conditions of coma, or under any circumstances in which the urine is retained for an undue length of time, lead, as is well known, to impairment of the vigor of the vesical detrusor. This may be only temporary, but where the impairment of the muscle function is at all marked, permanent atony of greater or less degree results. The normal sphincter immediately becomes under these conditions a relative obstruction to the overflowing urine.

An occasional condition which may lead to what I have described as loss of balance between the expulsive power of the detrusor and the resistancy of the vesical sphincter is fatty degeneration of the bladder. This is especially likely to develop in alcoholics.

The treatment of the condition of prostatism without enlargement of the prostate is not always very promising. In patients with a large amount of urinary residuum or complete chronic retention, infection occurs early, very often without surgical interference, *i. e.,* independently of the catheter or other instrument used for the exploration of the bladder or the evacuation of the urine.

I am well aware that my view on this subject is not consonant with the opinion held by the majority of surgeons, but I am satisfied that by no means all of the cases of so-called catheter infection in prostatiques are due to infection by dirty instruments. Germs or their toxins carried into the bladder from a urethra which is *ab initio* not aseptic, and transpelvic infection from the bowel, to say nothing of the possibility of infection directly from an infected blood stream, should receive more consideration than has hitherto been accorded them.

In the majority of cases prostatism without enlargement of the prostate, catheter and irrigations are perhaps the only recourse, if the patient's comfort alone is to be considered. In a certain proportion of them, however, the radical operation upon the vesical neck is distinctly indicated. If the kidney has begun to show symptoms of infection, or the catheter passes with difficulty because of a hypersensitive urethra and vesical neck, division of the sphincteric ring by the galvano-cautery or other method is the only logical recourse. Where the bladder is sacculated, the operation is especially demanded.

I am well aware that many surgeons claim ideal results from operations involving the vesical sphincter, but I am free to say, however, that in my experience permanent incontinence of urine is by no means unusual. The patient should be forewarned of the likelihood of such a result, for, while it must be confessed that the patient with permanent incontinence is safer than the one with retention, it cannot be urged that the wearing of a urinal is without its inconveniences and discomforts.

The mechanical desideratum is lowering the level of the vesical outlet until it corresponds more nearly to the plane of the floor of the *bas fond*. This necessitates, in the cases under consideration, a division of the vesical sphincter, a procedure which, as I have already remarked, is often followed by incontinence of urine—so often that he would be a foolhardy surgeon, indeed, who did not apprise his patient of the danger of its occurrence.

Treatment of Pneumonia.

By P. L. BELLENGER, M. D., Waterproof, La.

Ex-president Parish Board of Health; President Parish Medical Society.

I fear my few words before our society on the treatment of pneumonia were not sufficiently clear for practical purposes, and I will outline my treatment, which for twelve years I have adopted, with but one death where the cases were seen in their early stages.

I have not kept in tabulated form all of these cases, but have gathered together about fifty (50) cases—covering a period of two years, with a recovery of 98 per cent.

These cases ranged in age from four months to sixty-five years, the majority being colored, with very poor nursing.

It is not my purpose here to enter into the pathogenic changes in pneumonia, other than to say that we have an intense inflammatory condition with all of its attendant processes, with such physical symptoms as are usually present in all inflammatory troubles, such as pain, fever, quick, bounding pulse, combined with many nervous manifestations, more or less severe. It is at this stage I find the treatment more effective, generally giving in four doses, one every hour, the following: Mild chloride, 8 gr., sodbicarb. 10 gr., podoph. 1-4, equally divided. Hot or cold application may be applied as agreeable to patient.

Now to explain what results I expect from the above:

First: It will actually disgorge the liver and produce a flow of antiseptic bile, stimulate the gastric glands to proper action, thoroughly cleanse the whole alimentary canal, and leave your patient in a prime condition for the proper digestion and absorption of nourishment.

Second: It lessens the possibility of pneumococcic infection of the canal.

Third: It relieves some of the intense congestion without removing any of the corpuscular element, as it were, bleeding the patient into his own veins. Invariably, after the proper action of this valuable drug, in addition to the above, you will find your patient with a better pulse, fever lower, and many of the objectionable nervous phenomena gone.

At this time I begin with quin. sulph. in doses of 2½ grs. combined with one grain of pulvis myrrh, and give one capsule every three hours, which I have found at all times agreeable, given in the above combination.

The results I expect from its administration are as follows:

First: It inhibits the inflammatory forces in the affected area, often to such an extent as to make it manifestly perceptible on the pulse by reducing the resistance offered the flow of blood, thus lowering the temperature, aside from its known antipyretic action.

It is also valuable in antidoting any malarial trouble that so often complicates our cases here in this country. Again the unabsorbed quinin passing along the intestinal canal exerts some antiseptic influence on the pathogenic germs congregated along its course. Of course this action is not pronounced, but it unquestionably exists in a more or less degree.

I notice during the discussion the ovation given our good friend strychnin. This, too, is a valuable agent, but I fear much abused. It is not my custom to give strychnin in these cases until there is an actual demand for stimulation, as I cannot see the rational of giving a powerful stimulant where you only anticipate, in days to come, a demand, for in that case you will be obliged to give the drug in very much increased dosage. While it is quite popular with the profession, I cannot count it as a valuable remedy in pneumonia; but only an agent to relieve a condition which might exist, and that is better and more satisfactory relieved by nitroglycerin, which, aside from stimulating the heart to better and stronger action, it opens a way for the blood by diluting the peripheral vessels. I consider the alcohol treatment in pneumonia of no value, and in some cases positively harmful, except, of course, in the alcoholic subject.

Diet: This, of course, requires the supervision and judgment of the attendant physician, not so much as to the quality of food as to the proper intervals, which, to my mind, is vastly more important. It is my rule to feed not over four or five times during the twenty-four hours; thus I give the stomach a period of rest which, if necessary in health, is doubly so in disease. I am a liberal feeder, allowing milk, buttermilk, broth, soft eggs, rare beef, chocolate, tea, coffee, grits, mush and milk, and fruit, except bananas. This bill of treatment and diet has served me well, and I give it to you with a hope of having made clear the reasons of its efficiency. I frequently punctuate this with some simple cough mixture as needed.

I do not claim this as either original or specific, but I do claim that it places your patient in a better attitude to resist the disease, and that by the proper nourishment he will hold his own and the disease ceases itself. Towards the last I am in the habit of giving one single dose of the mild chloride, which, in many cases, hastens the end by from 24 to 36 hours.

My patients convalesce rapidly, and are rarely complicated by extensions.

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P. L. Thibaut, M. D., Chairman.

A Case of Uncinariasis.

By T. S. DABNEY, M. D., New Orleans, La.

In September, 1904, I was called to see a young man of about 18, on account of a peculiar skin affection occurring on his feet and right index finger. The young man was from one of the neighboring parishes, and with the exception of several years spent at one of the Catholic colleges of this city, had never been away from home. The main peculiarity of this eruption consisted in the skin's cracking open and rather deep and painful fissures were the result. Regarding the skin affection as what is commonly called "ground itch," and bearing in mind the well-known causal relation between that affection and uncinariasis, I promptly determined to look carefully into the case before treating the apparently trivial skin lesion.

Personal inspection showed a young man well grown, clear skin and sclera rosy, colored cheeks, no protrusion of abdomen, no mental hebetude. The heart sounds were normal, respiration easy and natural. Palpation revealed nothing abnormal with liver or spleen.

Upon questioning I brought out the following rather interesting data: The young man being the only son of educated and ambitious parents, naturally was himself very ambitious to achieve a name for himself in one of the learned professions; but try as he would, resolve as he would, to study hard, he could not fix his attention and keep it fixed for any length of time. An overwhelming sense of weariness, deepening into drowsiness and finally into sleep, would invariably render abortive all such attempts to forge ahead in his classes. Six to eight large meals a day and twelve to fourteen hours sleep failed to satisfy him. Finally, believing I had a case of uncinariasis to treat, I frankly informed the family of my opinion and ordered a simple lotion for the "ground itch," and a small dose of thymol for diagnostic purposes. Upon receiving a small quantity of hard feces, the diagnosis was *confirmed,* not *made* by the microscope. Through the courtesy of Dr. C. F. Sauter, the living worm, as well as the eggs, in the various stages of segmentation were seen. Drs. Halsey and Guthrie also kindly verified the presence of the Uncinaria Americana ova.

Prof. Halsey also made a careful differential blood count and demonstrated a marked eosinophilia, which in itself would have strongly pointed to some intestinal parasitic infection; but inasmuch as the eosinophilia was shown in a case of proven intestinal parasitical infection, it but accentuates the value of that symptom in blood counts. Dr. Halsey found 95 per cent. hemoglobinism, with no leucocytosis and with a normal amount of red blood cells.

This last is very remarkable in view of the well-known destructive effect this blood-sucking rhabditic nematode has on the red blood corpuscles.

After the diagnosis had been made from clinical data and confirmed by that arm of precision, the microscope, I determined to exhibit the case to the Orleans Parish Medical Society before the expulsion of the worms and the treatment of the concomitant symptoms. Accordingly I had the pleasure, on February 25, 1905, of exhibiting this case before my colleagues, the majority of whom favorably confessed that they never would have suspected uncinariasis in the rosy cheeked, well nourished, handsome young man presented.

Having seen many cases of this same disease under the name of ankylostomiasis, or tropical anæmia, I have chosen "A Case of Uncinariasis" simply to impress upon your minds, and especially upon the minds of my colleagues from the parishes—for bear it in mind, this disease is distinctly rural, and not urban—the great necessity of self-reliance, of using your own fingers before using the plessimeter, your ears before the stethoscope, your eyes before the magnifying glass. You and all of us are too prone to run to the bacteriologist for our diagnosis. This habit is rapidly converting us into machines, and now that our great pharmaceutical houses are doing such wonders in their line, the general practitioner will soon sink to the level of a sign post unless he wakes up and makes his own diagnosis and writes his own prescriptions and does his own thinking, and has his own opinion and only calls on the bacteriologist to confirm his diagnosis, warranted by clinical data, or to eliminate certain contradictory factors or, as a *dernier ressort* to differentiate for him between two closely resembling conditions. The time has passed when intelligent men, lay or professional, rest content with a laboratory diagnosis. It is hardly necessary to say that the bacteriologist has lost nothing by dividing the honors with the clinician, but now that each depends upon the other, and each knows his limitations, the old fogy doctor and the "closet" doctor have given place to better equipped, all-around men. So far as I know I was the first, or at all events one of the first, of the local profession to call attention to this disease. On May 14, 1898, I read a paper on Tropical Diseases before the Orleans Parish Medical Society, and in that paper (published in *N. Y. Medical Journal,* June 18, 1898), I called especial attention to that disease, its mode of contraction, its treatment and its prevention. To a pupil of the German Leuckart, Dr. Charles Wardell Stiles, we are indebted for the knowledge of the fact that we have endemic uncinariasis in the United States. In 1902 Dr. Stiles, then pathologist of the United States Bureau of Animal Industry, demonstrated the presence in this country of a new species of hookworm, the Uncinaria Americana. No longer need we fear the importation from the old world of the "germ of laziness," for, like the poor, we have it always with us.

To Dr. Stiles we are further indebted for having, by means of a trip from Washington, D. C., to Ocala, Florida, demonstrated the wide-spread prevalence and awful consequences of this disease. In the opinion of Stiles, uncinariasis plays a far more important part in the South than malaria, and he further maintains, and I fully agree with him, that uncinariasis is the most potent factor in the anæmia so prevalent in what he calls rural sand districts. Cities and clay soils do not seem to offer favorable conditions for the development of the disease.

Why the disease does not prevail in cities is readily understood, for the over-used air, moisture and shade to enable them to hatch and the latrine does not meet those requirements. The reason for the greater prevalence of Uncinariæ Americanæ (for they do occur in clay countries) in sandy than in clay districts is as yet little understood and all the reasons assigned therefor seem to me to be worthless.

Up to 1902 only 16 cases had been reported in the United States. Since that date the disease has been shown to be wide-spread, and physicians north, south, east and west are constantly testifying to its prevalence in their vicinity. Prior to Stiles' report (Bulletin No. 10, Feby. 1903, Marine Hospital Service) hundreds of unfortunates, notably in the pine lands, suffering from the ravages of ancinariasis, were dosed with quinin for malaria they never had, with iron for the anæmia due directly to the hookworm, and with cathartics to cure a dropsy due to cardiac exhaustion with astringents for intractable diorrhœas due to a general breakdown and relaxation of the intestinal walls. Stiles calls especial attention to a peculiar facial expression, a dull, blank, almost stupid, fish-like, cadaveric stare, which he claims is almost pathognomonic of the disease. It is hardly necessary to say this stare is found only in the well marked cases; when these cases of long standing come to autopsy, anæmia of all the organs and fatty degeneration of the heart, liver and kidneys is usually found. The mucous membrane of the jejunum notably shows innumerable bites, and in places is more or less necrosed as a result. The United States, through our colleagues of the Army and Marine Hospital Service (Ashford and King), has waged relentless war on this the most potent factor in poverty, ill-health and ignorance in Porto Rico, and I think a similar campaign among the "poor white trash" of this country would prove of inestimable value from an economic and sociologic viewpoint. It has long been an acknowledged fact that the residents of the oak and hickory lands (clay soils), the heavy lands, considered themselves superior in every particular to the "poor white trash" of the light or sandy soils. Now that we see a pathological basis for the inferior mental, physical and financial condition of these unfortunates, we should endeavor to alleviate their condition by thoroughly advertising its cause. The day of the pot-bellied clay-eater is gone, and a stalwart and intelligent people will populate that charming section of the Southland known as the Piney Woods.

In reporting this case I purposely put off to the last mention of its treatmenf, for thanks to Bozzolli, that is sò exceedingly simple. Bozzolli was the first to treat hookworm disease by means of heroic doses of thymol, fasting, giving, in rare cases, ten grammes in broken doses, a day. This dosage is rarely necessary.

A very good routine practice is to give a good dose of salts early in the morning and to follow, after purgation, with 20 to 30 grains dose, in capsule, every two hours until three such doses have been administered. In about two or three hours after the last dose, another purgative. Finally a large saline enema should be exhibited to wash out the worms and ova in the rectum. This enema should be at least a quart, and preferably two quarts, and should contain one ounce of sodium chloride to the pint. An enema of this strength will kill all worms found lodged in the rectum, and its exhibition materially shortens the treatment of the case. This treatment should be pursued every ten days until all ova disappear from the stools, or in the event of the want of a microscope, until the patient recovers *his health.* Simple, bitter tonics in the interim usually suffice to rapidly tone up the system and bring color to the wan cheeks and form to the sagging belly.

During the treatment oils and alcoholics should be avoided, as they are solvents of thymol, which is poisonous if absorbed in large quantities.

The patient, to avoid dizziness and other unpleasant sensations, should maintain the recumbent posture, the day he takes thymol. Food may be taken immediately after the last purgative is given.

In the last few years beta-naphthol has come to the fore as being safer and cheaper than thymol, and equally as efficient, and requires only half the dose.

As but few reports have come of its extensive use, judgment must be suspended as to all that is claimed for it. The May number of the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL has a brief notice of its use by Dupaquier.

Before closing I can not help alluding with admiration to the astounding ability of the early Egyptian physicians, who lived in a great alluvial plain furnishing every requirement for the robust development of the hookworm.

The oldest medical papyrus, according to Sandwith, extant, embracing in encyclopedic form the knowledge of these great teachers living on the mighty Nile, is what is known as the Ebers papyrus, so-called because Prof. Ebers, in 1873, whilst at Thebes, came in possession of this wonderful manuscript, written 3,450 years ago. This papyrus has recently been translated into German, and hence is available to all of us.

The most wonderful thing about this papyrus is that hookworm disease and its diagnosis and treatment are accurately described. Among the most prominent symptoms given are heart weakness, palpitation, stabbing cardiac pains, constipation, edema of legs, a weight in the body pressing heavily, and certain digestive derangements.

According to Dr. Joachim (1890) and Scheuthauer (1881), anæmia, due to hookworm, was well-known to physicians of that day under the names of A. A. A. and U. H. A.

DISCUSSION.

DR. GRÉMILLION.—I had the opportunity of observing six cases of uncinariasis. Dr. Holt encountered a case about four miles from Alexandria, in the alluvial district. Those cases which I had were in the pine region. Dr. Smith, of Atlanta, Ga., has often detected the hookworm in medical students attending lectures who showed no symptoms of illness. The older the patient is, the less marked is the anæmia, the older the subject is, the less danger there is of reinfection; because as they increase in age they generally wear shoes. Dr. Smith proved that the only way that the disease could arise was through the patient coming in contact with the ground-itch.

As to the anemia, it was so apparent that in my first case I suspected it, and in the other cases I made the diagnosis at sight. They did not come to see me particularly, but I made the diagnosis as soon as they came in. I believe as the Doctor says, we have lots of it in this country.

DR. SIMON.—We had, among others, three interesting cases in the Charity Hospital this spring. One case entered with mild anæmia, suffering from sciatica, and upon examination we found the hookworm. We then examined two other cases in the wards with sciatica, and found hookworms in each of them, though there was no marked anæmia to suggest it. We put all three patients on the thymol treatment. In two of these cases we got some apparent relief from the sciatica. It was suggested that this may have been a reflex condition from the bowels, possibly even toxæmic.

In the other case there was no relief, although we had used thymol for a period of three weeks, and relieved the patient of the worms. In our practice we have not always found thymol of such high specific value as the text books claim. We have been able to prove, by use of the microscope, that it takes at times two or three months to drive the ova of the worms out.

DR. C. C. BASS.—About two weeks ago, just as the medical students were leaving the city, I suggested to five of them who were in my office the taking of blood specimens. Four of them had increased percentage of eosinophiles, and examination of their feces showed them all to have hookworms.

I believe with Dr. Simon that thymol does not seem to be as good a specific as we would like to have, but I am impressed that there must be something in it after having seen a patient from one dose of forty grains pass a thousand worms, and in two months gain twenty pounds in weight and grow one inch in height.

Dr. Trahan.—We have been feeding a man on thymol three months; we examined his feces every week during all that time; we have purged him and given him thymol, and without any result. Once he was freed from the ova for just a short time. This patient, however, has improved very much. He was stupid, and scarcely knew his own name when he came. He is now able to go about, and do some little work.

Dr. Dabney (in closing).—I will state that if you gentlemen would use large saline enemata in anæmia, you would find the cases cut short. It is well known that the ova remains for weeks after you fail to find any worms. The eggs, by the purgation, are brought down to the rectum in great quantities, and are destroyed and washed out by strong saline enemata.

The Relation of Pleurisy to Tuberculosis.

By DR. SILVIO VON RUCK, Asheville, N. C.

Formerly the pleural cavities were regarded as exceedingly well protected against localization of bacteria, not only because of the protection afforded by the chest wall, but because the lymphatic system of the lungs during the movements of the chest in breathing was supposed to carry centripetally away from the pleura everything otherwise liable to reach it.

This view, based upon anatomic and physiologic hypotheses, was brought about by the discovery by Dyblowsky (1) of stomata upon the pleural surfaces through which the pleural cavities are in communication with the lymphatics not only of the diaphragm, as had already been shown by Recklinghausen (2), but of the lungs and thoracic walls as well.

The belief that the lymph vessels communicating with the pleura were all of efferent type was generally accepted, notwithstanding the fact that as early as 1867 Knauff (3) had prescribed the presence upon the pleural surface of net-like lymphatics containing coal particles showing the transportation through the lymph channels of corpuscular elements to the pleura.

Subsequently Arnold (4) showed by experiments in animals that inhalation of soot resulted in its deposit in the lymph vessels of the pleura. By his experiments he demonstrated that the pleural sac has not only direct efferent but also afferent lymphatics from the lung which are small and only demonstrable with the microscope. Arnold's work has been confirmed by Fleiner (5), who was able to trace coloring matter introduced experimentally into the lungs of animals, finding it deposited immediately under the endothelia of the pleura.

Quite recently Grober (6), in order to show the communication of afferent lymphatic vessels with the pleura, made inhalation experiments with Chinese tusch. He found regularly in the subpleural lymph nodes, likewise upon the parietal and upon the visceral pleura free tusch granules, and he has no doubt that corpuscular elements are transported to the pleural sac from the lungs.

While thus corpuscular elements or bacteria may readily enter the pleura from the lymphatics of the lung, the latter at least may gain access from the cervical and supra-clavicular glands, although these glands are in reality regional glands of the costal pleura. That metastatic processes may occur in a direction to that of the lymph current has been shown by Recklinghausen (8), and this fact Grober (6) applies in the relation of cervical glandular tuberculosis to pleurisy. Grober points out that when the cervical glands become the seat of tubercle, they swell thereby, causing lymph stasis and retrogressive flow, so that eventually the efferent vessels become afferent, carrying lymph to the pleura and with it tubercle bacilli from the cervical glands.

Again clinical observations of pleurisy, following tonsilitis, diphtheria and phlegmonous inflammation of the structures of the oro and naso pharynx would indicate the existence of a direct path from these regions to the pleura, and this Grober has demonstrated experimentally, showing that corpuscular substances when injected into the tonsils are transported by the lymphatics along the trachea, in the course of the great vessels, to the peritracheal, substernal and mediastinal nodes and the pleural apices.

There are various other paths by which corpuscular substances as well as bacteria may reach the pleura, as for instance, from the abdomen by upward extension through the diaphragm, by extension from mediastinal and bronchial glands, etc., but it would lead too far to attempt a discussion in detail of these questions. To the pathologist and to the student of experimental medicine these are interesting points for consideration, but for the clinician, the knowledge is sufficient that the pleural cavities are readily accessible to bacterial invasion from all sides.

That such bacterial invasion actually occurs with remarkable frequency is attested by the autopsy findings of all pathologists. Orth (9), for instance, in his work on pathologic anatomic diagnosis states that inflammatory adhesions of the pulmonary and costal pleuræ are found almost constantly present. The question now arises as to the relative frequency with which pleural inflammations are due to one or another exciting cause, and in this connection I shall confine myself more particularly to the role played by the tubercle bacillus.

That in the majority of instances inflammatory processes of the pleura owe their origin to the bacillus of tuberculosis is at once suggested by autopsy statistics which show that tuberculous lesions of greater or less extent are found in from 60 per cent. to 98 per cent. (Nægli) of all adults, and also by the much greater frequency with which tuberculous foci are found in the lungs and glands of the chest as compared with other parts of the body.

It is furthermore a significant fact that pleural adhesions are present almost without exception in individuals dead of phthisis, while also in the majority of cases in which pleural adhesions are found at autopsy, their relation to tuberculous processes in the lungs is more or less easily demonstrated microscopically.

Thus Smith (10) in 140 cases of pleural adhesions found pulmonary phthisis in over 33 per cent. and cheesy nodules in the lungs in a large number of the remaining.

In sixteen autopsies of subjects in which healed pleurisy was shown to be present Kelsch and Vaillard (11) were able to prove the tuberculous nature in each case, and Landouzy (12) from his autopsies found that 98 per cent. of his cases of so-called idiopathic pleurisies were tuberculous.

Had Smith resorted to histologic and bacteriologic examination of the remainder of his cases it is fair to presume that he would have been able to demonstrate a tuberculous origin in a still greater number.

It must be admitted that the simple finding of adhesions of the pleura together with tuberculous lesions in the lungs does not prove that the former may be secondary to the latter in all instances. The true relation can only be demonstrated in those cases in which it is possible by the microscope or by bacteriologic procedure to confirm the tuberculous nature of the pleural lesion.

Nevertheless the relative frequency of the tubercle bacillus as the cause of primary sero-fibrinous pleurisy has been well shown by microscopic examination of exudates, by animal inoculation, and by various other diagnostic means.

The former method is indeed highly unreliable, for attempts to find the tubercle bacillus in pleuritic effusions are rarely successful.

For example, Levy (13) examined fifty-five pleural exudates among which there were fourteen that were surely tuberculous, and found no tubercle bacilli in any of them. Ehrlich (14) was able to demonstrate them in two out of nine cases, and they have been found in exceptional instances by Frænkel (15), Renvers (16), Pansini (17), Grawitz (18), and a number of others.

During the past few years I have found them in two cases at the Winyah Sanitarium, in one of sero-fibrinous effusion and in one of empyema, both occurring in the course of pulmonary phthisis.

While tubercle bacilli in pleuritic effusions are rarely demonstrable by the microscope, cultural methods are likewise uncertain, as is indicated by the work of Lemoine (19), who made cultures from thirty-eight cases of sero-fibrinous pleurisy with the result that twenty-eight proved sterile. Yet fifteen of the latter cases afterward developed tuberculous pulmonary disease.

Quite recently, however, Jousset (20) has described a new method which he terms "Inoscopy," and by which means he claims to have demonstrated tubercle bacilli in twenty-three cases of sero-fibrinous exudates without exception.

Resort to animal inoculation affords a more reliable indication of the frequency in which primary or idiopathic pleurisies are tuberculous.

By this method Eichorst (21) was able to show that of twenty-three cases of serous pleurisy, in which no signs of tuberculosis were evident anywhere in the body, a tuberculous basis existed in 65.2 per cent.

Le Damany (22) inoculated guinea pigs with exudate from fifty-five cases. Tuberculosis developed in forty-seven of the animals, or in 86 per cent.

From his examination of forty-one cases, bacteriologically and by animal experiment, Aschoff (23) is of the opinion that the idiopathic pleurisies with serous exudate are almost exclusively tuberculous.

Grover (24), from the results of his animal inoculations, concludes that from one-third to one-half of primary pleurisies are tuberculous.

Prince Ludwig Ferdinand (25), Jakowsky (26), Weichselbaum (27), Kierner (28), Sacaze (29), and others have shown that serous and pleural exudates are frequently caused by streptococci, staphylococci and pneumococci, but that in the absence of these bacteria their basis is usually tuberculous.

Of particular interest is the work of Netter (30), who inoculated animals from three series of sero-fibrinous pleurisies.

Inoculations from sixteen cases in individuals known to be tuberculous resulted positively in eight instances, or in 50 per cent.

In twenty-five cases of idiopathic pleurisy a tuberculous basis was demonstrated in 10, or in 40 per cent., but in fourteen cases in which the pleurisy could be satisfactorily assigned to other causes than the tubercle bacillus inoculations proved negative without exception.

From a study of 109 cases of purulent effusion, the same author concludes that these empyemas in which only the staphylococcus is found are tuberculous in character.

The tuberculin test has been employed also by some authors in determining the frequency with which primary pleurisies are tuberculous, and the results from its application confirm perfectly those of animal inoculation. For example, Sears (31) applied tuberculin in ten cases of acute primary pleurisy with nine positive results, thus proving the tuberculous nature of the pleural affection in 90 per cent. of his cases. Also Netter (32) reported that 87 per cent. of his pleuritic cases reacted to tuberculin like cases of phthisis.

The experience of those whom I have cited, as well as of others, proves conclusively the fact that at least the overwhelming majority of cases of so-called idiopathic pleurisy are of tuberculous origin. Not only is this relation conclusively shown by methods of exact scientific diagnosis, but it stands in harmony with clinical observations in many instances in which the development of tuberculous disease has followed attacks of primary pleurisy after varying periods of time. To this occurrence many of the older writers called attention, but the carefully tabulated statistics of more recent observers afford interesting evidence.

V. Y. Bowditch (33) investigated in 1889 the subsequent histories of ninety patients treated for effusion by the elder Bowditch from 1849 to 1879. He found that thirty had died of tuberculosis, and at least one of those still living was tuberculous.

Hanford (34) reports five cases of pleurisy with effusion in apparently healthy subjects, three of whom afterwards became tuberculous.

Barrs (35) ascertained in 1890 that of fifty-seven cases treated at the Infirmary of Leeds from 1880 to 1885, twenty-one had died of tuberculosis.

Hodges (35) found that of 130 cases traced for seven years 40 per cent. developed tuberculosis.

Richochon (37) was able to follow carefully thirty-two cases of pleurisy occurring in his private practice and reports that tuberculosis developed sooner or later in all but two. From the literature he collected 310 cases in 178 or 57 per cent. of which tuberculosis ensued.

Fiedler (38) reported 112 cases of the sero-fibrinous variety, of which twenty-five subsequently died of tuberculosis and sixty-six others became tuberculous. Thus in over 80 per cent. tuberculous disease followed.

Examination of the history records of 1,000 patients included in the clinical material of the Winyah Sanitarium shows that in 201 cases pleurisy occurred prior to the onset of the pulmonary tuberculosis. In forty of these pleurisy was the initial symptom. In nineteen additional cases pain in the chest was said to have been the first symptom, and if these be added to the others, we have a total of 220 cases in which pleurisy preceded the pulmonary affection, or 22 per cent. That this proportion is too small I have no doubt, for I have not infrequently been able to demonstrate by physical examination evidence of old pleural thickening in patients who denied ever having experienced pain in the chest, or having had pleurisy.

With the various methods of precise diagnosis at our command there should rarely be great difficulty in determining the nature of a pleurisy with effusion.

The difficulty becomes greater in cases of dry pleurisy which occur in otherwise apparently healthy individuals and in whom physical examination reveals no evidence of tuberculous disease in the lungs, glandular system or elsewhere in the body. Such cases are by no means of uncommon occurrence. Still the fact that a dry pleurisy of greater or less intensity is a concomitant of practically every case of chronic pulmonary phthisis at some period of its course, should arouse the suspicion that we are dealing with a tuberculous affection in all instances in which no other satisfactory explanation can be assigned.

The inability of the observer to demonstrate by physical examination alterations in the lungs under these circumstances should never mislead even the most expert diagnostician. His knowledge of the modes of pleural infection should cause him to avoid hasty conclusions, for even a truly primary tuberculous pleurisy can possibly occur and tuberculous pleurisies are not seldom secondary to pulmonary foci, which are so insignificant as to escape the detection of the most skillful auscultator. To this consideration Weigert (39) has aptly called attention. In the autopsies of his cases he found regularly small tuberculous foci in the lungs immediately beneath the pleura, which he says could not possibly have been recognized by physical examination, nor could they have caused symptoms. To extension from subpleural pulmonary lesions most authorities agree that the great majority of tuberculous pleurisies owe their origin.

As has already been mentioned, pain in the chest is not infrequently claimed by patients to have been the first symptom of a tuberculous pulmonary affection, sometimes antedating the actual onset of active disease of the lungs by even years. In such cases when the inflammatory process is situated in the pleura of a lower lobe the pain is usually more characteristically acute, and stitch-like, and although too often diagnosed offhand as intercostal neuralgia, mistakes are not so often made. But in those instances in which the inflammation is in the apex of the pleura, where the respitory excursion of the pleural surfaces is limited, the pain is commonly not so acute. It is often described as a dull aching in the shoulder, at times radiating down the arm. In these cases the pain is frequently referred to rheumatism, whereas the true cause lies in the pleura.

In this connection it is well to call to mind the observation of Luschka that the phrenic nerve has a common origin with the brachial plexus and supplies sensory fibres to the costal pleura, thus explaining the radiation of the pain to the nerves of the shoulder and arm.

It should be remembered also that not only are the pleural apices the most frequent seats of pleural inflammation, as shown by autposy statistics, but the apices of the lungs are in almost all cases first affected in tuberculous pulmonary disease of the adult.

In the foregoing pages it has been impracticable without consuming too much time to consider the relation of pleurisy to tuberculosis, in minute detail. The purpose has been rather to review briefly certain salient points which permit of deductions that may be put to practical application, and which may be summarized as follows:

1. The pleural cavities are readily accessible to bacterial invasion.

2. The great majority of pleurisies with effusion which occur in otherwise healthy individuals are due to infection with the tubercle bacillus. This is proven by autopsy findings, by methods of exact diagnosis and by the subsequent clinical histories of the majority of persons who have been the subject of such attacks.

3. There is ample evidence to indicate that the so-called idiopathic, dry pleurisies are likewise usually tuberculous.

4. The subjective symptoms of inflammation of the pleural apices often simulated those of myalgia or rheumatism.

5. In every case of pleurisy or of persistent pain in the chest or shoulder which can not be satisfactorily ascribed to other causes, tuberculosis should be suspected, and a careful physical examination should be instituted to determine, if possible, the existence of a tuberculous process in the lungs, or elsewhere.

6. Even if physical examination in such cases proves negative, the patient should be regarded as tuberculous until the contrary

is proven, and should at least be kept under prolonged observation and re-examined from time to time.

7. The tuberculin test may be relied upon to confirm or exclude the tuberculous nature of pleurisy in case of doubt.

8. The application of these principles will often lead to an earlier recognition of tuberculous diseases of the lungs, especially, and to the institution of treatment at a period which will in many cases secure to the patient most important advantages in his prospects for recovery.

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DISCUSSION.

DR. KILBOURNE.—I am very much interested in these remarks, having had some personal experience with this subject myself. I want to call especial attention to the necessity and importance of early diagnosis of tuberculosis. The fact heretofore has been that we, as physicians, have failed to recognize sufficiently early the symptoms of tuberculosis, and our patients have had treatment deferred until all hopes of relief had passed.

There are many symptoms by which a diagnosis can be established before the ordinary symptoms upon which we ordinarily rely are used, and I think we ought to bear this in mind and take advantage of this fact in the early treatment, before the disease has made its inroads into the system.

Dr. H. D. Bruns.—The relation of pleurisy to tuberculosis has long been understood by observant clinicians. When I first began the study of medicine in 1879, my father, a general practitioner of large experience, impressed upon me to mistrust pleurisy, especially when occurring in young persons of, otherwise, healthy appearance.

Dr. Joachim.—The chief points that the paper suggests relate to the safeguarding the patient against the development of the disease. The circumstances seem to tend to prove that the forms of safeguarding which we have adopted do not overcome the disease itself. The glandular apparatus is in some places particularly vulnerable.

A point that was not made clear to me is that I cannot account for the spread of tuberculosis in animals by transplantation of material which does not show any tuberculous conditions.

I am glad that he mentioned the tuberculine test, because I think it is very valuable, as much now as when it first came out.

Dr. von Ruck (in closing)—The fact that tubercle bacilli can seldom be demonstrated microscopically in fluid from a pleuritic effusion, does not prove that they are absent from the fluid. It has been suggested that the bacilli gravitate, or are carried down mechanically by fibrin particles to the base of the pleura, which would account for their not being present in the upper portions of the fluid in the pleural cavity, in sufficient numbers to be readily found with the miscroscope.

That the great majority of such cases of tuberculous pleurisy with effusion they are present is proven by the positive results of experimental animal inoculation, and also by the work of Jousset, who, by his new method of inoscopy, succeeded in demonstrating them microscopically in every case of a considerable series.

The point which I wished more particularly to emphasize in my paper is the frequency with which pleurisy, or pain in the chest, antedates all other symptoms of tuberculous pulmonary disease. Hence, pleurisy, or pain in the chest, should be regarded as a timely warning, which, if not overlooked, will often lead to an early diagnosis.

I have in mind a case which serves as an illustration. The patient, who had been at the Winyah Sanitarium as a companion to a relative who was there under treatment, had had at times, for several years, pain in the shoulder, which had always been regarded as rheumatic. There was no other symptom to arouse the suspicion of a pulmonary affection, but on examination of the chest tuberculous infiltration in both upper lobes was found to be sufficiently marked to be readily recognizable, not only with the stethoscope, but by percussion.

The Use and Abuse of Glasses by Young People.

By OSCAR DOWLING, M. D., Shreveport, La.

You often hear the question asked, Why are so many young people wearing glasses? especially by older people who invariably say such was not the case when they were children. The universal idea prevails among the laity and many of the profession that glasses are not always necessary, but that the oculist feels it his religious duty to give them to all who apply at his clinic.

We know that glasses should not be prescribed except when positively indicated, because they are a nuisance, but when indicated they are necessary and should be worn. Many people wear glasses because they need them, some of them by error on purpose of the oculist or optician and the balance because they want them.

Any person suffering with headaches after using his eyes for reading, writing or other near work; if his eyes become red, irritable; vision blurred, along with numerous other symptoms, should consult an oculist. It is astonishing to see the number of people, among whom we are sorry to say are many physicians, who seek the advice of the optician, large numbers of whom in this section are self-constituted and even so-called DOCTOR, men who know not the first principles of refraction, and with absolutely no knowledge of medicine; men who could not detect a normal from an abnormal eye.

On examination, if a pathological condition exist, it should be our endeavor to correct same by proper treatment, but if the disturbance is due to an error of refraction, glasses should be given. The better qualified and more experienced as a physician, the better is the man prepared to practice ophthalmology.

We do not advocate that the oculist should treat the patient for constitutional disturbances, except in rare cases, as the constitutional disease properly belongs to the family physician. It is the duty of every family physician to see that his clientele receive the proper attention and that glasses are prescribed by a competent oculist when necessary.

Every man under the sound of my voice knows that hypermetropia, myopia and astigmatism require correction by glasses and that there is no other way to overcome the trouble. Hartridge says that "hypermetropia may be defined as a condition in which the antero-posterior axis of the eyeball is so short, or the refracting power so low, that parallel rays are brought to a focus behind the retina." In other words, the refracting media is greater than the length of the eyeball. Hypermetropes are commonly called "far-sighted," because they see distant objects without difficulty and near objects imperfectly. Hypermetropia is by far the most frequent condition of the error of refraction and is usually due to an arrest of the development. Hypermetropes of a low degree experience but little ill effects until the point is reached when the accommodation is not equal to the long sustained efforts at near work, then accommodative asthenopia is the result. This is likely to show itself after an illness, or if health has deteriorated from overwork, anxiety and sundry other causes. The patient complains, especially during the evenings, that the type becomes indistinct, the letters run together; after resting awhile, the work can be resumed, to be again laid aside from a repetition of the symptoms already mentioned. Frequent headaches, with a feeling of weight about the eyelids and a difficulty of opening the eyes in the morning, will be related to the examining surgeon. As the patient advances in age, he becomes permanently presbyopic, so that at thirty-five (women frequently at twenty-seven) he suffers from the same discomforts as an emmetrope of fifty. In order to bring out the total amount of hypermetropia, the accommodation must be paralyzed by the instillation of sulphate of atropine. When the accommodation is perfectly and completely relaxed, a much stronger lens will usually be tolerated, especially if there is any latent hypermetropia.

The normal refraction of an eye in early childhood is hypermetropic. Some remain so, a considerable number become emmetropic as they grow older and a small percentage pass to myopia.

The treatment of hypermetropia consists in prescribing convex lenses, such as will give the rays of light passing through them an amount of convergence so that they will meet on the retina without undue accommodation.

Myopia, commonly known as "nearsight," is the reverse of hypermetropia, so that parallel rays are focused in front of the retina. The eyeball is too long to permit distant objects being seen clearly, while near vision is perfect in low degrees. Myopia is usually acquired, hence it is chiefly found among students. Medium degrees of myopia are very common, but high degrees often increase steadily, assuming dangerous conditions, because they carry destruction to the important parts of the eye. Parallel rays focused in front of the retina produce diffused instead of clear images. The chief factors in the production of myopia are: Constant use of the eyes for near work, especially at an early age, when these organs are developing; disturbance of nutrition in the tissues of the eye, etc.

Statistics show that few cases of myopia are congenital. In myopia the patient sees distant objects badly, complains of pain and the eyes are irritable after using artificial light. There is most always a hyperæmia of the eyes and lids, with pain in the eyeball on pressure. For myopia there is a difference of opinion among authorities as to whether or not it is best to give the full correction. When the error has been estimated under atropine, unless it is very high, a great many oculists add a little to the lens found because the ciliary muscle is then completely relaxed.

Astigmatism. In the study of hypermetropia and myopia we find the trouble due to an eyeball that is too long or too short, but in astigmastim the curve of the cornea plays a most important part. Parallel rays falling upon it are brought to a common focus, there is a difference of refraction in the different meridians of an astigmatic eye; for example, parallel rays entering the eye in the perpendicular meridian may come to a focus on the retina, while parallel rays entering at right angle (in the horizontal meridian) come to a focus behind or in front of the retina. This condition may exist alone or in addition to hypermetropia or myopia when we term it compound hypermetropic or compound myopic astigmatism.

The causes of astigmatism are the same as those producing hypermetropia or myopia, but it is usually congenital, like hypermetropia. In this condition, as in others, to obtain reliable results, the eye must be thoroughly under the influence of atropine. Lenses properly fitted will relieve nearly if not all headaches due to eyestrain. In addition to the conditions mentioned, we have muscular insufficiencies, which are often relieved by the proper adjustment of glasses now and then combined with prisms.

Of 450 pupils in Mexico schools Uribe-Troucoso found 260 (57.7 per cent) had normal eyes and 190 some visual defect. Of the 190 there were 24.93 per cent hypermetropes (astigmatism included), 12.24 per cent myopes (astigmatism included). He dilates on the subject and finds the ratio changes as age increases, and myopia among normal school children becomes 19 per cent. He claims that myopia is less in Mexico than Germany.

Truc and Chavernac, in the common schools of Montpelier, in eight years, examined 6,445 students and found 24 per cent had refractive errors and 8½ per cent showed external lesions.

Sayer, of London, published last year the result of a series of investigations of school children in London. Eighteen hundred and sixty-four infants, between 6 and 8 years, were examined, and every three months' increase of age was carefully tested. The results were surprising, for it was found that at exactly 6 years of age 81 per cent. could read 6/6 with each eye separately and only 3.5 per cent had such serious defects that they could only see 6/18. The defects, however, steadily increased with every quarter of a year, until at 8 years old only 77 per cent. could see 6/6 with each eye, while 8 per cent had serious defects. He finds the percentage steadily increases, until at 11 years old it reaches 11 per cent, and then gets somewhat better again. Spectacles and the use of face rest, which will keep the face at least ten inches from the work, will overcome this.

Schleich examined the eyes of all those attending the schools and the university in the town of Tubingen, and of 4,196 eyes examined 65.2 per cent were normal and 34.8 per cent abnormal. Male students had 63.2 per cent normal and 36.2 per cent abnormal; female students 67.6 per cent normal and 32.6 per cent abnormal eyes. The most favorable conditions were found in the earliest school years and the most unfavorable in the last years of the gymnasium, where there were 27.7 per cent., in the realschule 15.3 per cent, in the elementary school 2.3 per cent, in the higher girls' school 6.5 per cent and the public schools 4.5 per cent. The frequency of myopia increased with the school years and the demands made upon the scholars.

Kunn, of Wein, from a study of the various theories held in reference to the causation of progressive myopia, lays down the following principles: The diagnosis must be made as early as possible. Glasses previous to the age of 6 years are unnecessary and dangerous from possible accidents. After this age they are imperatively demanded, as not only the ocular defect, but the accompanying physical and psychical conditions retard the development of the child. When the degree of myopia has been carefully determined, the glass which fully corrects this error is to be prescribed for constant wear. Kunn concludes that for the first few years the child should be re-examined three or four times a year to detect any change which may have taken place.

From the records in my office I have gleaned the following cases:

Mrs. E. D., 30 years old, came to me in 1900 complaining of eyes smarting, burning and watering. With her right eye she read 20/40 and with the left eye 20/50, while with +1.00 cylinder axis 90 she could read 20/20 with the right eye and with +1.00 sphere combined with +1.00 cylinder axis she read the same with the left eye. I insisted that she permit me to use the atropine, because I felt sure there was much more hypermetropia, and the ophthalmometer only showed +1 D. cylinder, ax. 90. She finally gave permission to instill the atropine, under which she read with the right eye 10/200, and accepted +4.00 sphere combined with +0.50 cylinder, ax. 90, and read 20/20. The same result was found in the left eye, save she could only read 8/200 with her natural eye. She was given +3.00 sphere, with +0.50 cylinder axis 90, for each eye, with instructions to wear them constantly. She experienced some difficulty in wearing them for forty days, after which she was decidedly comfortable with the glasses. I had occasion to examine her the other day and found her vision was normal with the glasses.

Early in 1901, R. B., white (male), 12 years old, constant sufferer from headaches when he goes to school, was brought to me by his mother. Vision in right eye was 20/200 and left eye

20/30. Under atropine he accepted: Right eye, +0.75 sphere, with +4.00 cylinder, and read 20/20; left eye, +0.75 sphere, and read 20/20. He was given the full cylinder for right eye and +0.50 sphere for left eye for constant wear. He had considerable trouble for months in wearing the glasses, after which he has done nicely.

Two years later his sister, V. B., at the same age, in 1903, was brought to me at the instance of the family physician. She was a constant sufferer with headaches. Vision in each eye was 8/200. Under atropine she accepted +7.00 sphere in each eye and read 20/40. I gave her the full correction for constant wear. Later she complained very much from headaches, when I found insufficiency of the recti muscles, so I had new lenses made with 2° prisms base out, which gave her relief for several months. Nearly two years later I could detect no progress in the myopia or increase in the muscular insufficiency, though I am sorry to say I found no improvement. She was referred to the family physician on account of the headaches, to no avail, when finally I prevailed upon her to allow me to remove a large adenoid, from which she had suffered more or less inconvenience for years. The operation was performed with no brilliant result, but we were unfortunate enough to have some infection, from which she suffered several days. I have not seen her for some time, and fear she is still suffering, or else she has fallen into the hands of another.

Mrs. H. F. W., aged 25, wife of an esteemed practitioner, consulted me for constant pains in her head, which kept her very nervous. With either eye she could read 20/15. She was wearing +0.50 cylinder axis 90 over each eye. Under atropine she accepted +0.50 sphere and read 20/20. The retinoscope confirmed this finding, so she was given the full correction, with the result that she has been perfectly relieved.

Mrs. J. F. W., 25 years of age, had gone the rounds of the opticians and various doctors seeking relief for headache, when she fell into the hands of a worthy practitioner, who suggested that she consult an oculist, and he finally induced her to visit my office. With each eye she read 20/15. She was wearing glasses +0.25 sphere, combined with +0.25 cylinder axis 90, for each eye. Under atropine she accepted +0.50 sphere, combined with +0.50 cylinder, and read 20/20 with each eye. I gave the full correction, with instructions to wear constantly. Two weeks later she returned with the information that she could see better at a distance without the glasses than with them. I explained to her that while she saw better without them, the strain was still there, and that if she would wear the glasses sixty days she could not do without them. From then until now she has not suffered with her headache, except one day she broke one of the lenses the pain returned, but was relieved when she resumed wearing the glasses.

Z. P., white, aged 8 years, headache, smarting and burning eyes, with dread of light, was brought to me in 1902 by her parents, who were opposed to her wearing glasses. On everting the lids I found she had follicular conjunctivitis. Vision in each eye was 20/200, with +1.50 sphere, combined with +0.50 cylinder, axis 180, she could read 20/30. I insisted that she should be refracted under atropine, but her parents concluded to wait. I gave them treatment for the follicular conjunctivitis, which was carried out by an uncle, who is a physician. One year later she returned with the conjunctivitis cured and vision in each eye equal to 20/40. Under atropine she read 20/20 with +1.75 sphere. She was given +0.75 sphere for each eye, with instructions to wear constantly. I saw her recently and found that she could read 20/20 without her glasses, but she tells me the pain in her head returns when she attempts to study without the glasses.

E. W. B., white boy, 7 years old, was brought to me for "crossed eye." Vision right eye was 20/30 and left (the crossed one internally) 20/80. Under atropine he accepted in his right eye +4.00 sphere and read 20/20; left eye +4.50 sphere and read 20/30. Retinoscopic examination confirmed this finding. He was given the correction, less 2°. Two months later he read 20/20 with left eye and four months after beginning to wear the glasses he read 20/20 and the eye was perfectly straight. When the glasses are removed the eye becomes crossed.

October, 1903, Mr. T. M. McB., aged 39, married, merchant, was sent me by his family physician. Vision in right eye equaled 20/30 and left there was light perception. Under atropine the vitreous was found to be full of floating opacities, and the ophthalmoscope showed what I thought to be a detached retina. There was no history of specific infection, despite I found the "shot-like" enlarged glands in the post cervical regions. He stated that he first noticed his vision failing three weeks previous on the temporal side, which was followed by a loss of vision on the nasal side, and then total blindness so far as recognizing objects was concerned. I gave the mixed treatment, cautioned him about diet, habits, etc., and requested him to return in one month. He reported twenty-nine days later, and you may imagine my surprise when I found the vitreous was almost clear of the floating opacities, the detached retina could not be found and his vision was 20/100. Under atropine he accepted +1.00 sphere, combined with +0.50 cylinder, in each eye, the axis being 60 in right and 90 in left. With the right eye he read 20/20 and left 20/30. Gave full correction for constant wear. I have not seen the patient for several months, but a few weeks ago I heard through his family physician that he was doing all right. He ordered another pair of glasses by mail. I have been greatly interested in this case on account of the rapidity with which the floating opacities were taken up, the marked improvement in so short a time and my mistake in taking something, I know not what, for a detached retina.

Mr. G. H. H., aged 34, traveling for the Picayune, New Orleans, consulted me nearly five years ago, and said he had been trying for years to get a glass with which he could read with some degree of comfort. He complained of being unable to read more than a few minutes before his eyes would begin to pain and compel him to stop. This man had been a constant wearer of glasses, some of which were fitted by opticians and one or two pairs by experienced oculists. Under atropine he could read 20/30 with either eye and +0.25 sphere gave him normal vision. Ophthalmoscopic examination revealed normal fundi. His lids were thickened slightly, with very red edges and soft epidermis scales. I gave him an antiseptic eye wash, a solution of protargol and a salve of yellow oxide of mercury, with directions to use for several weeks. He was advised to discard his glasses and quit smoking. In less than three months he was able to read for hours without any discomfort, and I am glad to say he has not experienced any inconvenience since then.

Miss H., a poor white girl, who labors for her living, aged 24 years, consulted a self-constituted doctor of refraction some months ago and was told that she had a severe disease of the optic nerve, and the only thing that would relieve her would be a pair of lenses made after his special method and with his molds. This girl was extremely neurasthenic and very much distressed on account of what she had been told. She was wearing a pair of minus lenses, which had been given her by an experienced oculist not far away. She was afraid to have her pupils dilated. Her vision in each eye was 20/40. After agreeing for me to use homatropine I instilled same and had her wait one hour, at which time she read 20/30 and with +0.50 sphere she read 20/20 with each eye. On everting her lids I found a few follicles in the retrotarsal folds in the upper lids. I gave her a solution of argyrol, 10%, with instructions to use it freely five or six times daily, and advised her to leave off the glasses. I neglected to say that the ophthalmoscopic examination revealed a perfectly normal fundus in each eye and the retinoscopic examination confirmed the test by trial lenses. Am glad to report that she has made an uneventful recovery with the assistance of her family physician, who gave her constitutional treatment.

We could go on with the history of many other cases, but these are sufficient to illustrate both the use and abuse of glasses.

Glasses are not an ornament and they do not improve the personal appearance or facial expression. They are a nuisance at best, and should not be imposed upon patients unless we have good and sufficient reason to believe their complaints are caused by existing ametropia.

Refraction has become a very important part of our practice and I am glad to say it is done with greater accuracy in this country than anywhere in the world. We are decidedly ahead of our European friends, who do not seem to attach so much importance to the details. In the clinics at London I saw case after case treated for conjunctivitis when the trouble was due to an error of refraction, while, on the other hand, I saw cases refracted and discharged that should have been treated for conjunctival troubles. They certainly are very indifferent about the fitting of frames. At Berlin I found them more painstaking in their work, but the same indifference about the frames prevailed. These deficiencies, no doubt, were occasioned by the crowded condition of the clinics.

In prescribing glasses we should endeavor to use our best efforts, as though each glass was intended for the refractionist, and use lots of common sense, as we cannot be guided by any set rules. Every case is a case within itself and must be so regarded by those doing the work. Theoretical knowledge is good and is absolutely necessary, but there are times when theory must go to the winds. The real conditions considered, the problems solved and eyes with errors of refraction protected by the use of proper glasses, while those due to other causes are protected from the abuse of glasses.

DISCUSSION.

DR. E. A. ROBIN.—I have no set paper to read in discussing this paper. I agree in the main, on the important points, with what the doctor has said, especially when he said that every case should be treated on its merits.

When prescribing glasses for young people, it is well to bear in mind the purpose for which they are given. In myopia we prescribe glasses for a double purpose. First, and most important, to arrest the myopic process; the second being the improvement of the distant vision. In this case I do not think it wise, as a rule, to order glasses until the child is 8 years of age, for the reason that it is my firm conviction that no child should be sent to school before that age. When glasses are prescribed for myopia they should be worn constantly.

We also prescribe glasses in cases of squints, and we give the glasses as early as possible. I have ordered them in the case of a child 3 years old, with success. Of course, it is not every child of that age who is sensible enough to wear glasses without danger through breakage. When we have amblyopia to deal with, proper glasses should be ordered when the child goes to school.

It is almost superfluous for me to add that we do not order glasses for anybody, even young people, unless they have defects. We are never satisfied that the eyes are free from defects until we have examined them under something reliable, such as atropine.

DR. R. W. SALTER.—I have known of hypermetropes that have gone through life without any inconvenience, unless their accommodation was taxed. One was a farmer boy of 15 years, with an error of four dioptres, who worked with comfort until he entered college, where he was compelled to tax his eyes, and it was but a short time after he was troubled with headaches. Gradle, of Chicago, after an analysis of 1,000 cases of errors of refraction, concludes that astigmatism was the most frequent cause of headaches.

DR. H. D. BRUNS.—I have only a few words to say and will not dilate upon those points which are of interest only to the ophthalmologist. I think there is so much refraction work done now for relief of headache, etc., that practitioners of medicine at large ought to be acquainted with the time consumed in such examinations and the thoroughness with which they have to be made if they are to be worth anything at all. What Dr. Dowling has said is only too true, that many men, even physicians, are satisfied with glasses prescribed by opticians. But in the vast majority of instances no man can know the true value of an optical condition unless the examination is thoroughly made under full paralysis of the accommodation. He is master of both physical and physiological optics.

If you had to test an optical instrument, change its focus every second, you can see that you could never measure the defects unless you could turn off this focus-changing mechanism. Now, how is it possible that one can know the optical defects of the eye unless he can turn off the action of the ciliary muscle and examine the eye in its static condition? Yet people will come to the ophthalmologist and expect him to correct optical defects in a few minutes, without the use of a cycloplegic. At this day the family physician should have an idea of the nature of these examinations and give the patient some idea of them before sending him to the specialist. It would seem that the majority of practitioners do not yet realize the tedious nature of the examination necessary before glasses can be intelligently prescribed. We are not content to-day, as we were twenty years ago, with measuring the refraction of the eyes only. We use habitually the instrument for measuring the curvature of the cornea, and we must examine the extrinsic muscles separately and collectively. This will very often take an hour, perhaps longer.

If these facts were known and appreciated by the profession at large we would find fewer pepole content to run in and get an examination of the eyes for the cost of a cheap pair of spectacles, which are usually sold to them at three or four times their value.

Dr. Dowling (in closing).—I can only thank the gentlemen for what they have said.

It very often happens that the family physician will tell patients they can go and have the work done in a few hours. It would be better if the general practitioner had a better understanding of the subject, as he could then explain to patients before they go to the specialist.

Society Proceedings.

Orleans Parish Medical Society.

President, Dr. L. G. LeBeuf. Secretary, Dr. Allan C. Eustis.
141 Elk Place, New Orleans.
In Charge of the Publication Committee, Dr. Allan Eustis, Chairman,
Drs. Jules Lazard and H. Dupuy.

Meeting of July 22, 1905.

Dr. Simon read a paper entitled:

Chronic Constipation and Its Treatment.

As one of the most common and widespread of the large group of minor ailments that flesh falls heir to, chronic constipation has scarcely received the careful and thoughtful attention at the hands of the profession in general that its broad and practical importance would seem to warrant.

While it is true in a sense that a mere faulty bowel functioning in itself rarely leads to serious consequences, still, when we consider the many annoying symptoms and perhaps troublesome sequelæ which often follow in its train, it is no wonder that in the minds of its victims at least the subject does not appear such a trivial one, but stands out rather as an ever live and pressing problem, calling loudly for relief. That this call has not been answered in all respects satisfactorily by the profession needs no better proof than the mere contemplation of the great numbers of secret and semi-secret nostrums which literally drug the market, gracing our public prints and billboards on all sides and at every turn.

The causes for this are fundamental and not far to seek. Our very training tends to make us look upon this and many kindred so-called minor ailments as too trivial for real serious consideration, whereas when the truth is known it is just these little troubles of mankind that take up a very considerable portion of our daily routine and tax our ingenuity often enough for relief.

The ordinary medical student will sacrifice much time to see a disarticulation of the hip joint or an ectopic gestation, let us say, whereas a lecture on chronic constipation, if such might happen to be in the curriculum, would be passed by with all but disdain. And still it is a subject the proper appreciation and understanding of which is a means, I believe, of no little value to the practitioner.

The condition, like the poor, is always with us, and is a source of no little worry to its victims, who imagine all sorts of dire consequences for themselves if their bowels do not move regularly each day. It bears, too, no relation to color, sex or previous condition of servitude, so to speak, but quite democratically selects its victims impartially, the young, as well the old; the poor, just as the rich.

From the standpoint of our evolutionary origin, it might be said, in a figurative way, to be a burnt offering among others we are forced to lay at the shrine of our higher civilization. Our more immediate ancestors of the ourang-outang family, it is true, may suffer their many worries of the wilds and jungle, but this is not one of them, nor can I believe would the little liver pills or pleasant pellets have a great sale among the aborigines of Darkest Africa.

In a word, it is our artificial and strenuous life, largely with its irregular and hasty meals, unsuitable diet, lack of exercise and ceaseless mental activity that stands responsible for the common prevalence of the trouble. These may be said to be primal factors producing the tendency among us all to chronic constipation, but they are by no means definite and specific enough to explain the individual case. For this we must go deeper and examine more closely into the pathological state, which, directly or indirectly, lies at the bottom of the condition in each case.

In the light of our present knowledge we may say that the disease, as it presents itself to us from whatever cause, falls under two great clinical groups, each demanding a more or less diametrically opposite line of treatment. These are, first, the atonic type, in which the muscle of the large bowel has to a large extent lost its tone, and thereby lacks in functional ability; and, second, the spastic type, in which portions of the large gut are in a state of catarrhal irritation and hypertonic spasm.

It is only within comparatively recent years that this sharp division has been made, and a thorough understanding of the subject in this light becomes an almost absolute essential to scientific and successful treatment. Formerly it was supposed that all cases were of the atonic type—a mere inactivity on the part of the muscles of the bowel—and, with this idea in view, treatment was directed solely towards a stimulation and toning of the abnormally relaxed muscle. While it is known to-day that a large percentage of the cases do actually belong under this category, still a not inconsiderable number, and probably equally as large, are rightly classed as of the spastic type, the failure to recognize which being responsible for the non-success in treatment in many instances.

The first essentials, then, in the treatment of a chronic constipation may be said to be a determination of its etiology and pathology as far as it lies in our power, and when this is done the particular and appropriate line of treatment can be fitted in with every hope of success.

The atonic form of the disease, which will receive first consideration, may be of true organic origin, or it may again be purely functional. And by organic may be understood a true and determinable pathological change in the nerves and muscle making up the mechanism of the large bowel. A typical instance of this is the constipation which almost invariably forms a part picture of a somewhat advanced tabes dorsalis. Here we can put our hands upon the definite lesion lying at the bottom of the trouble, which would be found in this instance as a sclerosis in the lumbar segment of the cord.

In like manner the constipation, or perhaps it would be better to say in this connection, the relaxed bowel and weakened peristalsis, following various other chronic organic cord and brain lesions, can be explained. These are cases, however, which rarely seek the doctor's aid primarily for a mere complicating constipation, but far more probably for the underlying nervous condition, and the constipation is only noted incidentally along with the other symptoms. It is needless to say in these conditions all efforts of curing the constipation independent of the original nervous lesion are futile, and the treatment in nearly every instance is at best but palliative. As a matter of fact, these cases should not be made to fall strictly under the head of chronic constipation in the ordinary accepted sense, since the underlying organic lesion is too remote in character and too far removed from the bowel proper.

As for organic changes centering in the bowel itself and leading to constipation, we know of but few instances. There is a congenital dilatation of the colon, accompanied by a persistent costiveness, which explains some of the intractable cases from childhood up; and, again, the surgeons speak of a hypertrophic rectitis, in which the rectal valves are made to play a large part in the causation of the disease, but I am inclined to believe, in the general average, both these conditions are rather rare.

Strictures and tumors and other such forms of bowel occlusion form an entirely independent chapter of their own.

It might finally be urged under this head, and with some truth, that a chronic catarrh of the large bowel is a frequent cause of constipation, but then, this is, after all, more frequently an effect rather than a cause, since every case of long continued costiveness, sooner or later, gives rise to a mild catarrhal state of the lower intestine.

We might say, then, that of the cases of what we might call primary chronic constipation which seek our aid, the overwhelming number are of a purely functional nature, and are, therefore, in contrast to the organic types, highly amenable to cure at our hands. Even the functional cases, however, it might still be urged, are in a restricted sense at best but secondary in themselves to some underlying operative cause, which, though true, is only half true, since the cause now is in itself a functional or constitutional one, and, with its removal, the bowel can be made to return to its normal functioning again. This very contention, however, should serve to bring home the lesson, which we must never lose sight of, that behind every case of atonic constipation there is some extraneous factor, some deviation from the normal healthy status, which we must seek for and attempt to remove before entering upon the treatment proper. This factor at the bottom of the trouble may be found to lie simply in some bad physical habit or habits on the part of the patient, such as a disregard or total ignoring of the desire to go to stool, or a lack, let us say, of the necessary daily exercise, and especially among those who lead sedentary lives; or, again, perhaps a faulty dietary, which means especially a lack of sufficient vegetable elements in the food.

The underlying cause may, again, be a far different and more serious nature. I refer to that large group of patients, principally of the female sex, who suffer from an enteroptosis, or general splanchnoptosis, in which the general abdominal relaxation is shared by the muscle of the large bowel. It is in these patients, too, and again especially in women who have passed through many pregnancies, that we often find the abdominal muscles themselves undertoned and flabby, which but adds another evil element to the general condition. The abdominal pressure is thus lowered and the expulsive effect considerably weakened. These many cases, familiar to us all, represent an important clinical type of the trouble and one which is particularly refractory to treatment until we apply a properly fitting abdominal binder.

The obesity type is also a sharply defined clinical one. Outside of the general lymphatic tendencies of these patients, the masses of fat in the abdominal walls and in the cavity itself form a positive mechanical hindrance to normal defecation.

Then, again, in the various anemias and cachexiæ of whatever nature, we find another factor, which may clear up the obscurity in etiology in many instances. In chlorosis constipation is an almost invariable accompaniment of the disease, and even led Sir Andrew Clark, wrongly enough, as we know, to suggest that it was the real cause of the trouble. The bowel mechanism, as we all learn, seems to be distinctly sensitive to a diminished nutritive quality of the blood, and, in point of fact, in every form of lowered vitality, chronic constipation forms an almost ever-present symptom. Thus could also be explained, at least in part, the many cases we find based upon neurasthenia and hysteria. Here, however, there is the additional element of nerve depression, which stands accountable for the tendency towards a general abdominal relaxation.

In various stomach conditions we might find another source from which we can trace a few of our cases. The list includes more prominently carcinoma of the stomach, and, in fact, all forms of pyloric stenosis, ulcer and the various types of hyperchlorydia. It is needless to say the stomch trouble demands our first consideration, after which the bowel condition will often be found to clear up of itself.

In senility, be the explanation what it may, and there is ususally a combination of many factors, an habitual costiveness of a very obstinate nature is rarely ever missed, and, in fact, it is just in these patients, as we shall see anon, that we expect to find the spastic form of the disease rather than the purely atonic.

The reason for this becomes at once apparent from the very chronic nature of the affection. Spastic constipation, pure and simple, is seldom a primary condition, but (and this is important) usually plants itself upon an already atonic bowel. Some even go so far as to say that every constipation of long standing, let us say of six years' duration, is of the spastic type, but it is best that no such hard and fast line be drawn.

Still this much is at least true, that the longer a state of constipation exists, the more likelihood there is for the presence of the spastic type. Every case of atonic constipation, from whatever cause, if it persists long enough, suffers the possibility of developing eventually into the spastic form. Where the boundary lies exactly becomes a matter for clinical study.

The origin of the spasm in the pathological sense can be found usually in a mild catarrh of the large bowel, which we may conceive can easily arise from the long continued irritation induced by an atonic constipation, with its retained hardened feces.

It is not that the entire large gut is in a state of spastic contraction, but only varying portions depending on the particular areas of catarrhal irritation. The regions of election, so to speak, are the transverse colon and the sigmoid, where there seems to be a natural tendency for the feces to collect and stagnate.

The catarrhal state thus induced may remain entirely quiescent except for the muscle spasm it tends to excite, or, as occurs in some instances, more outspoken symptoms may arise from it, such as attacks of diarrhœa, alternating with the obstinate constipation. Under these circumstances, the patient usually complains that for some reason or other he can never get his bowels in exactly normal condition—at one time too loose and again too costive—a statement which is at once suggestive of spastic constipation. Again, the attacks of mucous colitis, or membranous enteritis, which are only too often unrecognized, have their origin from an old, untreated spastic constipation, especially in those subjects who are likewise afflicted with a highly nervous temperament.

And not only in mucous colitis, but also in the plain, uncomplicated spastic constipation, does the nervous element seem to play as large and important role. The tendency of spasmodic seizures of the unstriped muscular tissues is a well known feature of the neuropathic diathesis, and thus it is in our neuresthenic and hysterical subjects we find spastic constipation a very early sequel of the atonic form, and perhaps even in a sense the primary condition. In all our high-strung and nervous patients, and in all cases of obstinate constipation of some years standing, then, the spastic type of the disease should be at once suspected.

At times it is solely this suspicion that might justify us in instituting the particular, pertinent line of treatment, for the typical symptoms of a spastic constipation, it must be confessed, are not at all times outspoken.

When present they consist of colicky pains, usually before defecation, or perhaps a varying tendency to colic on the slightest provocaton. The stools are commonly long-drawn out and narrow, with a caliber smaller than normal, it may be only of the thickness of the index finger. They may also appear as large, globular masses, but the hard, dry scybalous feces do not belong to the picture of this form of constipation.

Objectively the colon can be left in a state of contraction, hard, resistant and tender, and of smaller caliber than normal. This applies more especially to the transverse colon, which may be found on gentle, abdominal palpation, lying as a resistant mass easily movable above the level of the umbilicus.

Owing to the spasm, the patients experience difficulty in starting the act of defecation, and, when it is over, they feel as if the act were incomplete and that their efforts were only partially successful. Contrasted with the simple non-desire to go to stool in atonic constipation, the painful defecation due to the passage of hard, dry feces, the absence of colicky pains, the palpation of a large sausage-shaped, overfilled, relaxed colon, along with the history and general clinical picture presented, makes the differential diagnosis rarely difficult.

The diagnosis made, the next step is the treatment, and it is in applying the various methods suggested for each form of the disease that we best appreciate the importance of a clean-cut distinction between them. What is food for one, may, in a sense, be said to be poison for the other. In a general way, we might say, the main object in the atonic form is to stimulate the relaxed and inert bowel to increased tone and peristalsis, while in the spastic form the object would be primarily a relief of the spasm, and then, secondarily, a gentle stimulation of the intestinal glands, through a chemical irritation, however, rather than a mechanical.

Of the various means to accomplish our ends in both conditions, by far the most important is a judicious regulation of the diet. Any method of treating an habitual constipation which would ignore the diet is doomed to disappointment at the outset. A thorough understanding, then, of the elements of our foodstuff, as far as the relation to the bowel is concerned, becomes a necessity. In the pure atonic form we must first of all insist upon a diet which will leave the largest possible residue of indigestible matter to serve as a mechanical stimulus for the bowel. This includes, foremost, all foods of the vegetable type, and, along these lines, the green vegetables are of not nearly so much value as those of the tuber variety. The roots, such as potatoes, carrots, turnips, radishes, etc., are far more efficacious than spinach, lettuce or cabbage, and only because of the larger residue of cellulose they furnish. Other cellulose-rich vegetables, such as corn, peas, beans, celery, among others, are likewise indicated. Fruits of the variety of pears, apples, and the various berries, raw or cooked, have precedence over oranges, peaches, plums, etc. The list is too large to include all, but the principle remains the same throughout.

For similar reasons, all the cereals and the many cereal products on the market, heads from unbolted flour, such as Graham and rye bread, should also be added largely to the diet. Turk has conceived the novel idea of giving the plain bran, such as is eaten by horses, which can be macerated with milk or water and sweetened as a cereal. I have tried it in several instances with apparently much benefit. Meat and other nitrogenous foods leave little residue behind, and are, therefore, indifferent in their action in this respect.

While such a plan of diet, as outlined briefly above, has a specific effect on the atonic bowel, in the spastic condition it would be but adding fuel to the fire. Here we wish, above all, to avoid mechanical irritation of the bowel, which would but increase the spasm, and we, therefore, substitute a dietary, either inert in itself or which through chemical changes will tend to induce increased secretion in the bowel or perhaps a gentle peristalsis.

For this purpose we order the fruit juices of every variety—buttermilk, koumys, kefir or the plain sugar of milk, as suggested by Boas—a teaspoonful twice or three times a day. Milk and the casein products should be used with this caution, that in some they have a tendency to constipate. Butter should be ordered in large quantities, and perhaps, olive oil by mouth will be found of some benefit.

The use of olive oil by rectum, however, is for more efficacious than when given by mouth. It is, in fact, these very rectal injections of olive oil, or any other bland oil, which furnishes us our most valuable weapon for the relief of spastic constipation. The best plan to follow in carrying out this highly important procedure is as follows: The patient is to inject each evening, upon retiring, one pint of the oil, letting it flow in gradually from a fountain bag, the rectal tube not being inserted more than one foot. After this he is to turn over for his slumbers without too much stirring around. It is extremely rare, if the oil is given in this manner, for it not to be retained easily over night.

Here, now, is an agent which really works while you sleep, diffusing itself throughout the colon for hours, soothing the irritation and relaxing the spasm. In the morning, out comes the oil, along with the softened feces. The value of this plan in spastic constipation, the suggestion of which belongs to Fleiner, can scarcely be overdrawn, and along with the intelligent regulation of the diet makes up by far the most important part of the treatment.

In atonic constipation, besides the diet, we likewise have other procedures which are of valuable assistance. The oil enemas have no special application here, but, instead, we have recourse to massage, electricity and other physical methods.

It is through these external agencies, so to speak, that we hope to assist the bowel in regaining its tone. The massage of the abdomen, the technique of which cannot be entered into here, should be applied at least three times in the week. At the same time the abdominal muscles can be strengthened with the faradic current, or the positive pole can be introduced into the rectum, covered by a rectal tube. The precaution should, then, of course, be taken to inject some water first into the rectum. Of the value of electricity as thus applied, I have not been able to thoroughly convince myself, though it has the recommendation of some of the best authorities.

Among other physical methods the vibrator, one of our latest and best fads, deserves more than passing mention. The severe shaking up which it occasions cannot fail to insult the relaxed bowel and raise it to action.

I make but spare mention of these, not because they are not important in their way, but because space forbids my going further into details. Besides, it is only the specialists who can find time for these more elaborate methods in the busy routine of an office practice.

As to hydrotherapy, general measures suffice, remembering that for atonic constipation, cold is indicated, and for the spastic form, heat. Hot sitz baths for the latter deserve special mention.

As for drugs, they hold a subordinate but still not an unimportant part in the treatment. First of all, we can attempt to cure the underlying dyscrasia with proper medication. If an anemia is present, iron should be given; if a cachexia, say of malarial origin, arsenic; if neuresthenia, the proper nerve tonics or sedatives, and so on. It goes without saying that our first efforts in each instance should be directed against the underlying cause, if it lies in our power to do so.

For the constipation proper, remembering our pathology, strychnine would be indicated in the atonic form and contraindicated in the spastic type. Vice versa, belladonna is of special value when a spasm of the bowel is present and positively harmful in the relaxed condition. Since the nervous element enters so largely in the etiology of spastic constipation, a good plan is to combine the belladonna in the after-dinner pill with valerian, asafœtida, sumbul or musk.

In the atonic type we can order with the strychnine or nux vomica, cascara, colycynth, aloin, etc., all of which tend to whip up the desired peristalsis and secretion.

Drugs alone, however, will not cure a chronic constipation. With their assistance, plus the judicious employment of a suitable dietary and physical measures, with just a little sprinkling of patience and perseverance on the part of both patient and doctor, I believe the outcome in all respects will be eminently successful.

DISCUSSION.

DR. STORCK, in opening, stated that chronic constipation is often found in infants and was best treated by treating the mother. Whisky, brandy and paregoric, he stated, increased the tendency to constipation, and the foundation of the chronic constipation is often laid in infancy by the administration of drugs. Regarding the treatment of chronic constipation due to atony, he had had good results from abdominal massage by means of the ball roller. He had also had good results by the use of the faradic current, administered from ten to fifteen minutes. When he wished to practice massage and use electricity at the same time, he used a double bipolar roller over the abdomen, practicing this every day for the first week, every second day for the second week, and finally every third day. The double roller is preferable to the ball in thin subjects. The faradic current, administered by means of an intrarectal electrode, is useful in some cases. He considered the hygienic treatment of his patients of the utmost importance and he directed them to take a cold shower immediately after rising in the morning. Diet, hydrotherapeutic measures, gymnastics, regular times for going to stool, are all to be considered. Physostigma, or nux vomica, in connection with belladonna, when given to produce full physiological effect, give good results in some cases. The spastic form is best treated by Fleiner's oil method. The galvanic current may be of considerable value, particularly in enterospasm, free of pain. Belladonna, hysciamus and valerian are useful at times in the treatment of spastic constipation.

Dr. Guthrie stated that the treatment of chronic constipation by electricity was the most satisfactory, and, as a rule, attended with good results. He had failed utterly in obtaining any results by the use of drugs, but depended entirely upon hygienic and physical measures. He thought that it was not necessary to have a ball roller, as he had obtained excellent results by massage of the abdomen with the fist and also with a twelve-pound shot, covered with leather. He thought that not sufficient stress had been laid upon the importance of drinking large amounts of water.

Dr. Perkins had had excellent results in the treatment of this condition in children by giving them the juice from stewed fruits, mixed with a little cream, and he thought that the dilatation of the sphincter ani in the new-born was often of advantage.

Dr. Walet considered that regularity in going to stool and in eating meals should be insisted upon in the treatment of this condition.

Dr. Dabney had had excellent results by administering half an ounce of bran, swallowed with an abundance of water.

Dr. Simon, in closing, thought that too much stress had been laid upon the treatment of this condition by the several members discussing his paper and not enough stress upon differential diagnosis, which is the most important point, as the two varieties should be treated quite differently. Any appliances for the proper massage of the abdomen is beneficial in the atonic form, but all physical treatment is contraindicated in the spastic variety. He had not found any beneficial results in the use of electricity.

Meeting of July 29, 1905.

Dr. LeBeuf opened the meeting with the following address:

No experience in my eighteen years of practice ever impressed me more forcibly than just such a meeting as this held eight years ago in the room of this society, called by Dr. John Callan, the then efficient President, for the discussion of the same subject. It was also to try to educate the new men of our profession who had never seen this dreaded disease. At that time we had with us men who told us of just such a meeting called nineteen years before, in 1878. We are happy to say that most of these men are still with us. These two previous meetings, epoch-making as they were, undoubtedly also were the saddest occurrences of our corporate existence, and we must hope that this will be the last we ever will hold for this purpose. Let us trust that the work now being done along the line of destruction and protection, following the assertion, belief and dogma on the etiology of yellow fever, will mean the turning point of a new era, the regeneration from our former abject, hopeless condition to something definite, something tangible.

Let us remember how we felt twenty-six years ago. Let us remember how we felt eight years ago with nothing ahead of us, nothing which could be planned, nothing to combat. Prophylaxis in person always failed, prophylaxis in place always futile. No measure ever controlled the situation; no amount of disinfection ever helped, and when the entire truth was told, the only relief which came was when the frost of November appeared as a Heaven-sent Nemesis to our dreadful scourge. Today, the situation is different, and though we may not succeed entirely in this present campaign, though we may not check the disease at once (for various causes which will have to be told later), we hope to restrict it to some extent, to diminish its too extensive spread, and to instill some hope into our municipal fellow-citizens, a hope which will mean the regeneration and the rehabilitation of our dear city to the standard which she should have amongst the future great cities of our country.

I want to report, besides, that your advisory committee has been continuously and actively at work since last Saturday night. The task has not been the easiest and pleasantest. We will submit a very thorough report later when the work is over, and we hope then to show you that we have endeavored rigidly to conform with the principles which govern the disinterested, and high ethical standard established by this society. We have taken part in every conference, in every meeting called for the organization of the great work which is being tried in this city. One of the members of your society wrote the first instructions which were published last Sunday morning to govern all households regarding the control of the situation. Another member of the committee helped on a committee of three to plan and organize the up-to-date Emergency Screened Hospital, which was placed in operation in thirty-six hours. And though their names do not appear in print, nearly every important article or medical direction in the public press has been furnished or revised by your committee. As we are still actively at work in the campaign undertaken, we wish merely to report this as brief, temporary report until later, when we can give you a fuller and final report.

DR. POTHIER read a paper entitled:

"The Etiology of Yellow Fever and Its Transmission by the Mosquito."

The etiology of yellow fever can well be called a stumbling-block, for we can only record failures on this subject. Without recording the old ideas of miasmatic infection, we can look upon the work of Domingo Freire in 1885; of Carmona y Valle in 1885; of Sternberg, 1888, 1891; of Havelburg, 1897; of Sanarelli, 1897, as many failures which were more apparent after the work of Finlay, 1881 and 1891; of Carter, 1890, and especially that of Reed, Carroll, Lazear and Agramonte in 1900.

The consensus of opinion of all who have written on this subject, and especially in the light of the discovery of the mosquito transmission, is that the disease is due to an animal parasite on the order of the malarial parasite. The bacterial cause of the disease has been entirely abandoned. Everything points to an animal parasite if we can reason by analogy, though the fact that the disease can be transmitted by direct inoculation may be considered as opposed to this theory. Unless we accept, without knowing, the idea that the animal parasite of yellow fever has a sexual and an asexual cycle, and that reproduction can take place without an intermediary host. The idea has also been advanced by Dr. Finlay that the parasite may be the reverse of that of malaria, that is, that the sexual cycle takes place in the human body, while the asexual cycle takes place in the mosquito.

From all the work done in the etiology of yellow fever, we do not know yet the cause of the disease, and it is still to be discovered. We know, however, its mode of transmission, by the mosquito.

The transmission of diseases by suctorial insects is not a new idea,—it was prevalent among the Romans, among the Chinese two and three thousand years ago. In 1498 Bishop Kund thought that the plague was propagated by flies. Maulfils, in 1776, says that anthrax is caused by the bite of flies, and Nuttall cites a number of authors from 1780 to 1868 who believe in the theory that certain diseases are propagated by insects.

J. C. Nott, of Mobile, is the first, however, to incriminate insects as the propagators of yellow fever; his article appeared in 1848. Dr. Charles Finlay, of Havana, in 1881, advanced the theory that mosquitoes were responsible for the dissemination of yellow fever. It was left to Reed, Carroll, Agramonte and Lazear to establish definite proof that the disease was transmitted by the mosquito. The report of the work done is familiar to all, and need not be reviewed.

The conclusions of the Army Yellow Fever Commission were that (1) Yellow fever can be produced by direct subcutaneous injection of blood from a yellow fever patient. (2) That yellow fever can be conveyed by the bite of mosquitoes having previously bitten subjects suffering from yellow fever. (3) That the Sanarelli Bacillus is not the cause of yellow fever. (4) That they were unable to discover the cause of the disease.

The experiments of transmission of yellow fever to healthy individuals were reported by the Yellow Fever Working Party No. 1 in 1902, and the results were the same as those obtained by the Army Yellow Fever Commission.

The mosquito incriminated by the experiments made in Cuba by Reed, Carroll, Agramonte and Lazear is the stegomyia fasciata. They established further, that the mosquito became infected during the first three days of the disease, and that after this period they could not be infected. It was also proved that during a period of twelve days the infected mosquitoes were unable to produce the disease, and that after this period the mosquitoes invariably produced yellow fever in non-immunes which they were allowed to bite. This is the summary of our knowledge of the transmission of yellow fever by the stegomyia fasciata, and before concluding I wish to say a few words on that mosquito.

The stegomyia fasciata is invariably a cistern mosquito, as can be ascertained by referring to the report of the Mosquito Commission of the Orleans Parish in 1901. Of 200 cisterns, barrels, troughs, etc., examined in 1901, the larvæ of stegomyia were found alone in 104, and mixed with culex stimulans and fatigans in 24. The eggs are deposited on the surface of the water by the female, and lie scattered, not in clusters or masses as the eggs of culex. These eggs hatch in ten to 24 hours, giving rise to larvæ which are full grown in 8 days, and develop into the pupæ, which, in turn, releases the imago in two days. The markings of the mosquito are characteristic, and can be observed with the naked eye. It is the female that bites, and may be recognized from the male by the fact that the antennæ are free from the heavy hairs of the male antennæ. The other markings are common to both, the legs are striped white and black; there is on the thorax dorsally white lines simulating an M, and a white line extending across the thorax at the point where the wings join the body. The abdominal segment dorsally is striped black and white, and laterally there are six or seven small white spots corresponding to the rings of the abdomen. On the thorax laterally are also small white spots about five or six in number, reminding one of five spot of the dice, or of the six of the domino. There are no special markings of the wings that we can see with the naked eye. As to the larvæ, they may also be differentiated by the fact that they are more active, and that their breathing syphon is more barrel shape and stouter, and of a darker color than culex, their position to the surface being about the same as that of culex, probably a little more vertical.

(No discussion.)

DR. J. H. WHITE's paper, "The Prevention of Yellow Fever and Federal Regulation of Infected Localities," will be published in these proceedings in the next issue of the Journal.

DR. HOLT read a paper entitled:

The Treatment of Yellow Fever.

In the course of my remarks on the treatment of yellow fever, I mention to you now that, for clearer illustration, I may use mixed metaphor, and if so, you will know that it is intentional, and no apology necessary.

This subject is one that may be briefly epitomized or hugely extended. It may be condensed into a very small brochure or expanded voluminously, according to literary proclivity. One may have much to say in little, or little in much. As for myself, I can better respond to your wish by repeating, while fresh in mind, and with some enlargement, my reply to a young physician a few evenings since, who propounded these questions: "Doctor, please tell me, do you give quinine in yellow fever, and what do you consider the best treatment of the disease?" My esteemed young friend, you are just entering the gate-way of experience, and I hope you may find wisdom without paying over-dear for its possession. As to quinine in yellow fever, I ask, why, what has suggested it? "Well, Doctor Osler advises it." Yes, my dear boy, and he further tells us that neither emetics nor purgatives are now employed, and when hemorrhage sets in to use perchloride of iron; all of which is enough to make a New Orleans physician collapse in fatal syncope. Let Doctor Osler pursue this course in Baltimore, where they have inhabitants, perhaps, overcrowded and to spare, but to advise it as permissible in New Orleans, he merely declares to us that he has passed his forty mark by many decades, and for the sake of his yellow fever patients, should have been chloroformed long ago. We send him a counter recommendation in the Kibby cot and ice-water affusion. They will surely settle the business for Baltimore. No, sir; after your initial and preparatory measures give no drug, and least of all, a nauseous one, when you know that the stomach already is moving on in dreadful haste in the direction of a supreme crisis, a disorganizing and hemorrhagic congestion, whose terminal may be black vomit and speedy death. Why do you speak of quinine, knowing that you are dealing with a poison possessed of the putrefactive virulence, invoking alike universal sepsis, a liquifying spoliation of the blood and hemorrhage, with rapid tissue changes and softening, of the fatty degenerative series, such as characterize also the venom of the fer-de-lance, and both alike touching the life of all the blood corruptibly. Did it ever flash into your mind, young gentleman, the close geographical kinship between yellow fever and the family of crotalidæ, represented in the fer-de-lance, the moccasin and the rattlesnake? Of course it is coincident, but is more than merely coincident. I call it a geographically localized creative tendency; as witness China; all things yellow and one pervasive, absolutely unique odor, and numerous even more striking evidences of such like qualitative kinship in nature, geographically limited.

As to what you shall give in yellow fever, let me cover a wide field in a few words. But let me say to you right here, that your duty is in behalf of your patient first, and to the protection of your people second, and not to the furtherance of pharmacological inquiry. In responding to this dual duty, you must have the backing of your own strong integrity; of a courageous manhood; and conduct yourself so clearly in your high office that you may command unquestioning confidence in the face of any trial; quail not under a covert threat. Far better to forfeit your life in a glorious martyrdom for truth than to have your people to cry out in their distress, like Job, rising in his affliction: "But ye are forgers of lies, ye are all physicians of no value!"

Concerning treatment, I tell you now that every known energy and substance, excepting, to date, the X-ray and radium, have been ransacked in the quest of a specific; and, in that particular, we are today where we were one hundred years ago.

In assuming the care of a case of yellow fever, the physician must have clearly defined a mental picture of the four stages of the disease, shading one into the other, in progressive unfolding; recognizing and interpreting each in the succession of symptoms. To do this makes the skilled diagnostician, and without it there is no such thing as a masterful, a safe and judicious treatment. Right here lies the difference between the trustworthy yellow fever physician and the wholly unreliable physician, because, not skilled in this bed-side interpretation; and so the whole question rests finally on this power. From observation I will boldly say that the most dangerous allies of yellow fever—excepting, of course, first and always, the man who chooses not to recognize the first cases when he sees them glaringly, and suppresses information of the first sparks of pestilence, from motives of cowardice, or his own little rascally preferment—next to him, but far less criminal, is the charlatan and blatant ignoramus with diploma or not; close behind is the educated physician, long in practice outside the yellow fever zone; simply because he brings his accumulated experience to bear in confident assurance in the one, lone, absolutely unique malady, the most mysterious on the planet. With a big heart and a generous, helping hand, a complete and sacrificial offering of self, he plunges into the treatment of an infection that holds its destructive sway in the unseen world of matter, in its operation, the analogue of the rattlesnake among things visible. Named by its nature, it should be called *Noli me tangere,* and no such dignified warning name, misapplied to a chronic ulcer.

In every variegated diamond, in the triangular, square-jawed head and sullen eye, you see in the rattler written all over by the hand of nature, *Noli me tangere,* and so in the outward signs and inward working of yellow fever. "Provoke me if you dare! I hold this patient, and in me is the issue of life and death; hands off!"

In the symptomatic movement through its stages we note the chill, speedily followed by a fever of variable intensity and duration, let us say, from twenty-four to seventy-two hours, declining abruptly or gradually into a listless stage of intermission or of marked remission. This is the treacherous vortex calm following the storm of primary assault of the true poison itself. This calm may be final in death or convalescence; but usually, on the third, fourth, or fifth day comes the secondary storm, from a new direction, and due to septic and other toxic consequences, and the enormous obstructive accumulation of tissue debris. The successful elimination of these secondary toxines introduces the last stage, convalescence; its failure means death.

Simply recognizing the composite detail of this picture: the gathering storm, the approaching crisis in destructive congestions and probable hemorrhages; the universal degenerative changes; oftentimes localized inflammations; and, always, the obstructive tissue wreckage; this picture before your eyes, the treatment of the disease suggests itself. First, last, and all the time, your defensive cry is, elimination! That one word, and gentle ministration in hygienic care, covers, with rare exception, the whole field of your ability: "For whatsoever is more than these cometh of evil." A firm self-control, and a strict interpretation of symptomatic evidence, is your panoply in the fight.

To have a strong or reasonable hope of success, the treatment must begin early; certainly within the first twenty hours. Later than that the precious time is forfeited.

Your initial step is eliminative without irritation. According to age, physique and urgency, from five to fifteen grains of calomel, but no bicarbonate of soda, given preferably in a teaspoonful of fine ice. Four hours later, a full dose of an active but mild purgative, such as the stomach is most likely to bear; no pills. The old time infusion of senna, manna and salts, or a full dose of castor oil, made as agreeable as possible, or an active saline water. This may be supplemented by a large enema if not unduly exciting to the patient. Where the stomach is gorged with a recent meal or things hard of digestion, empty quickly with an emetic, first thing. When the stomach has been cleared and the bowels freely relieved of their entire contents, you have reached your limit of vigorous medication; and like Paul in the tempestuous Euroclydon: "When the ship was caught and could not bear up into the wind, we let her drive."

Go on favoring elimination, and your safe friend is water, cool or cold, plain so, or any modification, as a light lemonade, Apollinaris, vichy, the light, pure fruit juice additions or Buffalo Lithia ad libitum. For high fever, a large bowl of warm water and free wet toweling of the body; but never ice, or anything cold, applied externally. The guarded ice-bag to the hemorrhagic stomach is the only exception. To further aid in control of high fever, small one or two grain doses of phenacetin or acetanelide, or such like, according to preference, may be given, and repeated in two hours if required. Invoke only the gentle effect. Everything gentle and non-irritant in all that you do. Comfort is itself a powerful remedy.

The calm stage calls for absolute rest; a little Ducros' Elixir, with ice or water, if acceptable, or Panopepton and water, if preferred. The use of a small, soft catheter is sometimes imperative; watch for retention.

In the fourth, fifth or sixth day we reach a danger line in the resumption of nourishment. The state of the stomach and its ability to bear must be our guide. Until the red edged and pointed tongue, and the oral mucous membrane and gums have paled from their appearance of acute erythema, you must proceed with exceeding caution in nourishing your patient; a little haste in premature feeding, giving too much or too rich, or any kind of solid, may readily irritate and rush an otherwise well progressing case, into gastric hemorrhage, and into uncontrollable recurrent fever, or tornado, let me rather say. For such hemorrhage, actual or threatened, I give ice freely, sometimes with an eighth or twelfth of a grain of cocaine hydrochlorate. Here I use ice as a poultice over the stomach, carefullly guarding against excessive refrigeration by one, two or three thicknesses of flannel or towel between ice-bag and skin. Iced champagne is sometimes grateful, but often soon tired of; Ducros' Elixir is generally liked better, Panopepton, or sometimes a little weak, very fine brandy.

As the evidences of acute inflammatory action subside, begin with three or four teaspoonfuls of iced milk with one-fourth of lime water, or milk and vichy, half and half. Repeat in an hour or two, and the next day increase the quantity, alternate with a delicately prepared chicken broth cooked with a little rice or barley, strained out. Then go on and nourish as you would a mild or desperate case of typhoid fever. I allow no preparation of beef. No fresh meat the balance of the season.

The secondary fever on the third or fourth day means obstructed elimination, usually intestinal, and calls for a very gentle but thorough purgation, aided by mild enemata.

Depression of pulse below fifty calls for strychnia, one-thirtieth to sixtieth of a grain, hypodermically, but not always so, and repeated according to your judgment.

Be cautious with alcoholic stimulation, knowing the fatty changes in the liver(the acute and sub-acute inflammation of the gastro-intestinal tract. Alcoholic subjects generally die; big meat eaters close behind.

Concerning the kidneys pathologically, you know that they, too, are in a state of profound degeneration, with such epithelial disintegration and the crowding of tubules with toxine and combustion products, you are not surprised at the interference, and often complete annihilation of function; the uremic convulsions and death.

This condition plainly tells you to refrain from drugs, in the hope of forcing function. They simply will not functionate under your rude command. Be persuasive; keep the bowels freely opened, and remember that water is your kindest friend. A light, cold whey with seltzer or vichy does a double work in nourshing and elimination. The number of things given and done more than this are, in the face of this pathology, irrational, fussy, and often harmful. In using them you must confessedly say you do not really and sincerely know what you are about. I am not talking about your notions and a case you once saw recover. Our case has reached a climax, for better or for worse, and drugs are not going to solve it.

Now, dear fellow, this is all I have to say. Professional tact and experience will fill in the finer touches of detail. If you will do just a few things with masterful precision, and self-restraint, and patiently watch with hopeful expectation and a fair confidence in the regenerating power of nature, you will have done all that you ought to have done; and will have left undone the things you ought not to have done, and wisdom is justified in her son.

Now go to bed, my boy, and think about all this tomorrow; which, by the way, is Sunday. Good-night.

(No discussion.)

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Quarantine Versus Sanitation.

Physicians should at once inaugurate a campaign of education calling attention in their communities to the impossibility of efficient land quarantines on the one hand and to the magnificent results of sanitation on the other. With yellow fever of course we mean by sanitation mainly the destruction of mosquitoes and their breeding places. With other communicable diseases the procedure would be different according to the method of transmission, but the principle would be the same.

During the prevalence of yellow fever in the South this season there have been numerous instances where the most rigid quarantines have not kept out the disease, and at least as many where scientific methods either controlled it or stamped it out where it was introduced. We shall mention no names for the present, but it will not be difficult for any of us to find object lessons for our respective jurisdictions.

Intelligent restrictions and precautions will prove to be more productive of good than attempts at absolute non-intercourse.

Fake Preventives.

Nothing is sacred to the quack or to the manufacturer of fake patent medicines. They aim to profit through disaster and misery and would not spare the dead if the departed could swallow their villainous stuff. The daily papers are accepting and publishing advertisements of patent medicines, which are now suddenly claimed to be preventives of yellow fever, and, inasmuch as their managers well know the falsity of the claims, they must be considered as partners in crime of the dishonest dealer and maker. Every physician's mail is crowded with literature, written for the purpose of lauding the wonderful efficacy of this or that preparation of the prevention of yellow fever. The note of insincerity and falsity is easily discerned by the intelligent medical man, yet the insult offered through the effrontery of the advertisers is exasperating.

If some of the public is deceived, harm is done indirectly because the slightest degree of faith put in the fakes may interfere with the carrying out of really important measures. We should all warn our patients to that effect.

The Yellow Fever Germ.

Three pathologists of this city, Drs. Pothier, Hume and Couret, have announced the discovery of certain cells in the blood of yellow fever patients. They find them during the first three days only—once on the fourth day. They have not as yet traced them to the mosquito, and make no extravagant claims relative to their find, realizing that a good deal more has to be done before they can know and the profession can believe that they have isolated the cause of yellow fever. Their statement appears in the *Journal of the American Medical Association.*

Two other microscopists, Drs. P. E. Archinard and Guthrie, are known to have also found something new in the blood of yellow fever patients, but they are very careful and conservative when questioned and have as yet made no definite announcement.

If either or both sets of observers have discovered the germ and can follow it into the mosquito from man and vice versa, one of the most interesting, important, and far-reaching events in medical science will have to be chronicled.

THE ALKALOIDAL PHARMACEUTIC method calls for the extraction from the leaves, roots, seeds and bark of a plant (whatever part contains its active principle) of the substance which makes the plant valuable for our armamentarium, and if that alkaloid, resin or concentrate is divided into mathematically exact doses and these doses are offered to the doctor in the shape of soluble, elegant tablets or granules which please the eye and do not offend the nose or taste, can be depended upon to do the same thing upon every occasion, we can say that the method of alkaloidal therapeutics is an improvement upon prior conditions.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of Dr. F. W. Parham, Assisted by Dr. F. Larue, New Orleans.

A Not Generally Recognized Late Poisonous Effect of Anesthetics.—Most surgeons, whether they prefer chloroform or ether as their anesthetic, have been disposed to believe that if chloroform did not kill *during the anesthesia* the danger was over, whilst on the other hand ether manifested occasionally remote effects that might in some measure be responsible for fatalities. Ether was thought to be especially contraindicated in pulmonary and renal affections, and many, who habitually used ether in these cases, would prefer to use chloroform.

Late investigations, however, cast serious doubt upon the reliability of such conclusions; indeed, seem rather to show that at the least chloroform is quite as likely to cause renal irritation, even degeneration, as is ether. We ourselves believe that ether is less dangerous in renal affections than chloroform, and the more recent literature would seem still further to establish the position of ether as the safer anesthetic, because the reports of fatal results from chloroform narcosis show remote effects not heretofore understood.

Two articles bearing on this point have recently appeared. The first is that we had the pleasure of hearing Bevan read in abstract before the Portland meeting of the American Medical Association, and now published in full in the Journal of the American Medical Association of September 2 and 9, entitled "Acid Intoxication and Late Poisonous Effects of Anesthetics." The article is based on the report of the case of a girl, 12½ years of age, operated on under chloroform anesthesia and dying four days later with certain degenerative changes, apparently due to the poisonous action of chloroform in a somewhat prolonged narcosis. The signs of acute fatty degeneration of the liver and kidneys were found at the autopsy, probably explaining by hepatic toxemia the condition which during life was diagnostically very obscure, puzzling some of the most expert clinicians. Bevan frankly admits that the true interpretation of the conditions was not revealed until an exhaustive study of the literature of the subject had been made.

This examination showed somewhat similar cases reported under various titles, such as "Some Fatal After Effects of Chloroform on Children," "Fatal Acetonemia Following an Operation for Acute Appendicitis," "Acid Intoxication," "Aciduria ("Acetonuria"), Associated with Sudden Death After Anesthesia," "Acute Yellow Atrophy of Liver," "Protracted Effect of Chloroform with Fatal Termination." Many cases, he thinks, have undoubtedly been attributed to late shock, fat embolism, sepsis, meningitis, uremia, etc., which should properly have been ascribed to the anesthetic. Whilst we do not believe that Bevan and Favill have incontestably demonstrated that the cause of death of their patient was chloroform, still it seems clear that it had much to do at least with the fatal toxemia, originated possibly by the gangrenous ovary. One thing seems certain, that just in such cases as the one related must we be particularly careful not to subject the patient to protracted or repeated narcoses, for in such cases the already beginning intoxication may easily be lighted up by the anesthetic into a toxemia that may end fatally.

The other article referred to is one by Leonard G. Guthrie, on "Aciduria (Acetonuria), Following the Administration of Chloroform and Ether," published in the *Lancet* of August 26, 1905. Some of their conclusions are as follows:

First—That both ether and chloroform are dangerous under conditions, at present undetermined.

Second—That the symptoms suggest acid intoxication by the poisonous precursors of acetone.

Third—That the origin of such bodies is in the disintegration of fat.

Fourth—That in all deaths from anesthetics fatty metamorphosis is found in most organs and in the liver *par excellence.*

Fifth—That acid intoxication arises from such fatty metamorphosis.

Sixth—Although prolonged administration of chloroform certainly produces general fatty metamorphosis, it is incredible that such profound changes can be induced by small doses in short operations.

Seventh—Ether is not capable of producing similar changes, yet they are found apparently to the same extent in deaths following ether as in deaths after chloroform.

Eighth—It, therefore, follows that such fatty metamorphosis must have existed prior to the anesthetization.

Ninth—In any case the pre-existence of fatty change must be presumed.

Guthrie concludes his very valuable article with some very thoughtful suggestions regarding the preliminary treatment of patients who are subjected to operation under anesthesia.

While both ether and chloroform are to be regarded as potential for harm, we are compelled, in the light of such reported cases, to revise our notions of their relative safety and to be more careful in controlling the duration of our anesthesias.

Both articles are timely and contain so much of instruction which we cannot give in abstract that we must refer our readers to them, with our most hearty commendation.

Department of Obstetrics and Gynecology.

In Charge of Dr. P. Michinard, Assisted by Dr. C. J. Miller, New Orleans

Cesarean Section in Late Labor.—R. W. Holmes, *Amer. Jour. Obst.*, believes that this procedure is not a justifiable one and that the appropriate time for abdominal hysterectomy is at term before labor has begun or not long after active contractions have been in progress. The contraindications to the Cesarean section in late labor center in the following facts: Prolonged labor lowers the woman's resistance to shock; conduces to atony of the uterus, therefore to hemorrhage, occasionally necessitating hysterectomy; it develops certain effete substances, which are eliminated more slowly than they are produced, and which lower immunity by a species of autointoxication. During protracted labor certain secretions are poured into the uterus and vagina, which offer excellent culture media for the development of bacteria normally present in the parturient canal or introduced by examinations. After the membranes are projected through the os externum, or the head has molded into the os, they are exposed to the contamination of the vagina; in removing the secundines and the child through the uterine incision they may soil the peritoneum or wound. The prolonged labor frequently is the determining factor in the death of the child, or so jeopardizes its life that its prospects are curtailed. Holmes deprecates the Cesarean section performed with inadequate assistance, filthy surroundings and makeshift facilities. An emergency operation should not be done unless there be pressing indications.

PSEUDO-ASCITES IN OVARIAN TUMORS AND ITS CLINICAL SIGNIFICANCE.—Karl Hormann (*Münch Med. Woch.*, March 21), tells us that free fluid which is found in the abdomen in ovarian tumors is not true ascites, but a secretion from the epithelial covering of the tumor. This secretion may be free in the abdominal cavity, and after a time give rise to epithelial implantations on other parts of the abdomen, or it may come from perforation due to rupture of a cyst into the abdomen, this cyst continuing to secrete fluid which increases that in the abdomen. If this fluid is thin it may be absorbed; if it is thick and contains much mucin, it cannot be. If this fluid is obtained by puncture, and is found to contain much mucin, it is from a ruptured cyst. The author describes two cases which illustrate the subject. In the first there was a large amount of fluid in the abdomen, which appeared to be the secretion from a cyst the size of a hen's egg. There was undoubtedly a pseudo-ascites. There had been a spontaneous rupture of the cyst and a high grade of inflammation of the parietal and visceral peritoneum in Douglas' cul-de-sac. The case was at first believed to be malignant on account of the bad condition of the patient, who was very thin and had palpitation, and because of the rapid growth of the tumor. An exploratory operation resulted in the withdrawal of the thick fluid, and the tumor was easily removed, with the happiest results to the patient. The second case had a similar appearance of malignancy, but was also proven to be non-malignant.—*Amer. Jour. Obst.*

THE MORTALITY OF OPERATIONS OTHER THAN STRUMECTOMY, IN CASES OF EXOPHTHALMIC GOITER, WITH SPECIAL REFERENCE TO GYNECOLOGICAL OPERATIONS.—Dr. Barton Cooke (American Jour. Obst.) has investigated this subject at some length, and not only gives his own experience, but that of 167 American surgeons.

Forty-four surgeons reported seventy-one cases. Of this number fifteen died. The operations were general and included all from minor to capital surgery.

In thirteen of the fifteen fatal cases the cause of death is expressly stated as acute thyroidism, with tachycardia to an extreme degree, and eventual heart failure. Excluding two cases, one of combined sepsis and thyroidism, and one of death while under chloroform, the mortality from thyroidism was 16.8 per cent., including them 19.4 per cent. The character of the operations seems to have made little difference in the results. The mortality of the minor operations was 16 per cent; that of the others about the same. It appears, therefore, that the existence of exophthalmic goiter adds more than 15 per cent to the mortality of any operation performed upon the patient. Consequently, an operation of election, such as suspension of the uterus or plastic operations on the vagina should be considered unjustifiable on such patients, unless a preparatory or curative treatment is discovered that will lessen the danger.

Local anesthesia may be demonstrated to be preferable to general anesthesia, but while the subjects of exophthalmic goiter cannot be said to take an anesthetic well, the alarming symptoms of acute thyroidism do not, as a rule, appear during or directly after the anesthetic, but usually at the expiration of a day or two, when the effects of the anesthetic have worn off. Possibly the best results may be obtained with Barker's method of employing adrenalin chloride and B. eucain.

If thyroidism develops Hirt advises the administration of suprenalin extract in 3-grain doses. Intravenous injections of adrenalin chloride may prove more efficacious than the tablets by the mouth, and in the presence of urgent symptoms this would be his method of choice.

Department of Therapeutics.

In Charge of Dr. J. A. Storck, New Orleans.

Physicians Should Remember that the United States Pharmacopœia of 1900 is now official.

Dry Cups in Herpes Zoster.—Leale emphasizes the fact that the careful and scientific application of dry cups has proved of great value in the treatment of herpes zoster, both in shortening the duration of the disease and in ameliorating the symptoms. The dry cup should be applied over the ganglia of the posterior roots and over the points of emergence of the nerves involved. This is done just to the affected side of the spinous processes of vertebræ over the area determined, several being applied and allowed to remain long enough to insure their maximum suction power. They can be reapplied if deemed necessary. Then a few cups are applied over the course of the nerve or nerves involved. In this we are guided by the seat of the pain and hyperesthesia and by the location of the eruption. Leale makes it a practice to cup early, in many cases before the eruption has appeared, when, of course, it is difficult or impossible to distinguish it from a simple neuralgia. He usually finds it best to repeat the cuppings once every twenty-four hours, and preferably just before the patient settles down for his night's sleep. In this way a nocturnal paroxysm of pain can often be prevented and rest secured.—Jour. A. M. A., Sept. 2, 1905.

SCOPOLAMIN-MORPHIN ANESTHESIA.—Seelig presents a series of sixty-five general anesthesia administrations, including abdominal and vaginal hysterectomies, operations for hernia, hemorrhoids, plastic operations, curettements, uterine fixations, appendicectomy, nephropexy, thyroidectomy, etc. In every instance the patient received a hypodermic injection of scopolamin hydrobromate, grain 1/100, and morphin, grain 1/6, one-half hour before the administration of the general anesthetic. General anesthesia was induced by means of the ethyl chlorid-ether sequence administered through the Bennett inhaler, especially modified for this purpose. Seventy-seven per cent of the patients did not vomit. One-third of the patients who did so, vomited only once. Nausea was never pronounced except in two cases, and vomiting never occurred earlier than two hours after operation. Seelig expressed himself as thoroughly satisfied with the method.—*Jour. A. M. A.*, Sept. 2, 1905.

RADIUM EMANATIONS.—Phillips carried out some therapeutic experiments on seven patients with diseases of the ear, nose and throat with a properly constructed tube, the interior of which was coated with radium. The method was found to be useless.—*Jour. A. M. A.*

TONIC EFFECT OF CHLOROFORM ON THE LIVER.—Nothnagel, having pointed out that fatty degeneration of the liver occurs after the administration of chloroform, Doyen (*Lyon Mèdical,* Feb. 26, 1905), gave a dog the drug by the stomach in doses of 25 to 50 cubic centimeters daily, and examined the liver after its death, which occurred on the fourth day. He found that this organ contained about three times the normal amount of fat and that there was considered cellular necrosis throughout the organ.—*The Therapeutic Gazette.*

GUIACOL IN THE TREATMENT OF PNEUMONIA.—Dr. William George Cain tells his experience in the treatment of pneumonia with guiacol. During the past season there has prevailed in his section an epidemic of a fatal type of lobar pneumonia. Having been favorably impressed with a few cases successfully treated with guiacol a year before, he thought best to adopt the same method. The number of cases treated was sixteen, with no mortality. Guiacol was used in doses of from 5 to 30 minims, according to age. It was rubbed into skin of the chest or abdomen every twelve to twenty-four hours. The skin was first cleansed to promote absorption. Then the guiacol was slowly dropped and rubbed in with one finger. If the fingers are all used, much of the medicine is absorbed by them, besides making them rough. The chest was protected by a flannel jacket. The bowels were kept well opened. A soda, alcohol and water bath was given at least once a day.

The diet was light, with plenty of warm, fresh air. Anodynes, expectorants, tonics and stimulants were seldom required. In most cases no internal medication was employed except laxatives.—*The Therapeutic Gazette.*

WILLIAMS DISCUSSES THE THERAPEUTIC VALUE OF THE VARIOUS EUROPEAN SPAS, PARTICULARLY BAD NAUHEIM.—He says that the treatment can be obtained elsewhere than at Bad Nauheim and that this spa possesses many unpleasant features and some decided disadvantages. From the points of view of climate and accessibility Nauheim is by no means a place to which a cardiac patient should be advised to go. The treatment is quite unsuited to the great majority of cardiac disorders, and its indiscriminate recommendation, even when dilatation is the most prominent objective feature, is by no means free from danger. In deciding on the respective claims of the numerous spas at which cardiovascular diseases may be treated, it is necessary to take into consideration various factors. In general, it may be said that any spa at which gout is properly treated is potentially a spa suitable to a cardiac lesion. It must be remembered, however, that physicians at such resorts are not as a rule in the habit of dealing with cardiac disorders, and, furthermore, that certain health resorts, the waters of which are well adapted to the gouty, have specialized in troubles of the cardiovascular system. To get the best results from spa treatment, patients should be treated in the earliest stages, in the stage of arterial spasm, which has not as yet led to organic change.—*Jour. A. M. A.*

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr. J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First St., New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist., Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. District, Sunset.

MINUTES (*Continued.*)

Upon motion, duly seconded and carried, Dr. Southern, one of the Councillors of the Mississippi State Medical Association, was made a guest of the society.

NEW BUSINESS.

The Secretary read a communication from the American Medical Association, suggesting that the dates of the State meetings be changed so that the meetings would be held in the fall or early winter, so as not to conflict with the meeting of the American Medical Association.

Dr. Callan moved that the matter be referred to the Executive Committee.

Motion amended to the effect that it be referred to the Executive Committee for study and report to the Society. Carried.

The Secretary read a communication from the Chess, Checkers and Whist Club, tendering the use of their rooms to the members of the Society during the convention.

Dr. Gremillion moved that the invitation be accepted, with thanks. Carried.

Dr. LeBeuf moved that the names of the regular physicians not registered, reported by the Councillors, be referred to the State Board of Medical Examiners, and they requested to take proper action. Carried.

Dr. J. A. Gaar, of Weston, Jackson Parish, stated that his parish was unorganized, and that he desired to become a member of the Society under the provisions of the constitution.

Dr. Joachim moved that the application be referred to the Councillors for a report. Carried.

Dr. E. D. Newell, of St. Joseph, inquired whether it would be in order to discuss the report of the Committee to Study Changes in the Constitution.

The President ruled that this might be done by unanimous consent.

Dr. Newell moved that the By-laws be suspended, to take up the matter for consideration. Carried.

Dr. W. M. Perkins moved that the various recommendations be taken up seriatim. Carried.

The Secretary then read the first recommendation, suggesting that the nominating committee should consist of fourteen members instead of seven as at present, amending Chap. 4, Sec. 2 of the By-laws.

Dr. W. M. Perkins moved that the Nominating Committee consist of fourteen members instead of seven as heretofore, to consist of two members for each congressional district. Carried.

Dr. Ayo inquired whether this provision would go into effect at once, stating that the By-laws required that the Council elect the members of the Nominating Committee on the first day, and they would want to know whether they were to elect seven members or fourteen.

The Secretary then read the following recommendation of the committee: "We believe that the choosing of the Nominating Committee, for many and obvious reasons, should remain in the hands of the Society, and that they should be elected by the members of the respective congressional districts."

Dr. Perkins moved that the By-laws be changed in accordance with this suggestion. Carried.

Dr. Martin moved that these two amendments go into immediate effect. Carried.

The Secretary then read the next recommendation of the Committee: "We believe that the By-laws would be made clearer by embodying the following changes: First—Constitution, page 9, Art. 6, Sec. 3, limits eligibility to office; therefore, the By-laws, Chap. 1, Sec. 1, should mention such limitation."

Dr. Perkins moved that the by-law read: "Except as provided for in Sec. 6, Art. 3, of the Constitution." Motion seconded.

Dr. Callan offered an amendment by adding the following words: "And he must be in the active practice of medicine." Dr. Perkins and his second accepted the amendment. Carried.

The Secretary read the next recommendation of the committee: "By-laws, Ch. 1, Sec. 4, should read as follows: 'Each member in attendance at the annual session or any special session shall enter his name, etc.' "

Dr. Smart moved that the change be made so as to make this provision apply to special meetings as well as to regular meetings. Carried.

The Secretary then read the next recommendation: "By-laws, Ch. 3, evidently provides for annual meetings, and 'annual meeting' might be inserted."

Dr. Perkins stated that that section should refer only to the annual meeting.

Dr. Martin moved that the change be adopted. Carried.

The Secretary read the next recommendation, as follows: "By-laws, Ch. 5, Sec. 3, directs that the Treasurer shall subject his accounts to such examination as the Society may order, and shall charge upon his books the assessments against each member at the end of the fiscal year. We think it would be better to order an annual auditing of the Treasurer's books, and to direct the charging of the assessments as they become due."

Dr. LeBeuf moved that the recommendation be adopted.

Dr. W. M. Perkins offered as an amendment to that portion of the recommendation relating to the auditing of the Treasurer's books the following: "His accounts shall be audited annually by a public auditor, at the expense of the Society."

Dr. Amedee Granger offered a substitute for Dr. Perkins' amendment, as follows: "A public accountant shall be chosen and paid by the society." Carried.

The Secretary read the next recommendation of the committee, as follows: "By-laws, Ch. 8, Sec. 1, 'Ten days in advance' should read 'sixty days,' in order to afford the officers ample time for the preparation of the reports."

The President stated that that related to the Secretaries of the Parish Societies.

Dr. Perkins moved that the change be adopted.

Dr. Martin offered as an amendment that it read "thirty days." This was accepted and carried.

The Secretary then read the next recommendation of the Committee, as follows: "By-laws, Ch. 11, Sec. 11, should read sixty days instead of thirty days, for the same reason."

Dr. Perkins stated that in view of the action taken on the other recommendations, he believed that it would be proper to leave this section as it now is, and so moved. Carried.

Dr. Perkins stated that the Constitution does not provide for the election of members residing in unorganized parishes, and moved that the clause read as follows: "Art. 4, Sec. 2, Constitution, 'The members of the Society shall be members of the component societies, also physicians otherwise eligible from unorganized parishes, who may be elected.'"

The President suggested that this be made a provision of the By-laws instead of a change of the Constitution, which could not be acted upon until the next annual meeting. After some discussion the motion was amended as follows:

Sec. 4 to be Sec. 5, this new Sec. 3 to read: "Any properly qualified physician from a parish having no component society may be elected to membership at the annual meeting, after his application has been in the hands of the Secretary thirty days, and has been approved by the Council.

Dr. Perkins moved that this new Section Three be adopted. Carried.

Dr. Martin called attention to the fact that it would be necessary to elect a Nominating Committee, and suggested that it would be well to take up its election at a time when there would probably be the best attendance. He suggested as a good time immediately after the morning session on the first day.

Discussed by Drs. Parham, Martin, Ducote, Barrier, S. A. Ayo, Patterson and Perkins.

Dr. Martin then withdrew his original motion, and offered the following: "That the members from the various congressional districts shall meet between the morning and afternoon sessions on the second day, and each congressional district shall elect two members of the Nominating Committee." Carried.

The President read a communication from the Boston Club, tendering the use of their rooms to the members during the convention.

Dr. Barrier moved that the courtesy offered be accepted, with the thanks of the society. Carried.

Adjourned until 2:30 p. m.

(To be Continued.)

Medical News Items.

Owing to the Present Conditions of quarantine the opening of the Medical Department and of all other departments of Tulane University is postponed from October 18 to November 2.

Twelve of the Governors of the Southwest have signed a call for a meeting to be held in Chattanooga on November 9 to discuss quarantine and immigration.

Meeting of the Louisiana State Board of Medical Examiners is Postponed owing to the present uncertain conditions of travel. This meeting was to have been held October 20 and 21.

The National Confederation of State Medical Examining and Licensing Boards Has Postponed its annual meeting, which will most likely be held in the early part of the winter, according to the announcement of the Secretary, Dr. Felix A. Larue.

THE SEMI-ANNUAL REPORT OF BIRMINGHAM'S HEALTH OFFICER shows the death rate among the negroes of the city to be larger than the birth rate. The negro birth rate per 1,000 is 21.12 and the death rate 33.32. The crowded quarters in which they live, which makes tuberculosis very prevalent, is assigned as the cause.

ANY ONE HAVING NUMBERS 2, 5 and 6, Vol. 16, 1859, issue of the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, will confer a great favor by communicating with the JOURNAL. P. O. drawer 602, New Orleans, La.

THE JONES COUNTY MEDICAL ASSOCIATION held a good meeting at Ellisville, Miss., on September 13.

PERSONALS: Dr. E. G. Ballinger has been made associate editor and assistant business manager of the *Atlanta Journal Record of Medicine.*

Dr. H. H. Harrelson has been appointed by Gov. Vardaman as a member of the State Board of Health to succeed Dr. John H. Rhodes, who died suddenly on September 2.

Mr. F. C. Godbold was honored with the vice presidency at the annual meeting of the American Pharmaceutical Association, held in Atlantic City September 4.

DIED: Dr. Thomas Menees died at Nashville on September 7, aged 83. Dr. Menees was elected a member of the Confederate Congress and remained a member of that body until the dissolution of the Confederate government. Deceased had been professor of obstetrics in the Medical Department of the University of Nashville and Vanderbilt University.

AT THE NEXT MEETING of the Mississippi Valley Medical Association to be held at Indianapolis, Ind., on October 10, 11 and 12, the annual addresses will be delivered by Dr. Arthur R. Edwards, of Chicago, and Dr. W. D. Haggard, of Nashville, Tenn.

Dr. Edwards has chosen for his subject, "Certain Phases of Uremia, Their Diagnosis and Treatment," and Dr. Haggard will discuss "The Present Status of Surgery of the Stomach." In addition to these addresses there will be the annual address of the president, Dr. Bransford Lewis, of St. Louis.

A cordial invitation is extended to every physician in the valley to attend this meeting, for which a large number of valuable papers have been promised.

THE MEDICAL COLLEGE OF INDIANA has been turned over by its faculty to the Purdue University, a state institution. The college faculty owns about $100,000 of property which it transfers absolutely to the trustees at Purdue University.

THE ORLEANS PHARMACEUTICAL ASSOCIATION has issued to physicians a card reminding them that the new Pharmacopœia became official on September 1, 1905, and giving a list of some of the radical changes, especially in the strength of potent tinctures.

A LIST OF CHANGES that became effectual on September 1, 1905, according to the 8th revision of the United States Pharmacopœia, has been issued by the H. K. Mulford Company, who will be glad to send a copy of this to any of the readers of the JOURNAL. They are preparing a small folder suitable for pasting in prescription blank giving the changes, so as to be a ready reference in the writing of prescriptions. Copies of these folders will also be furnished our readers upon request.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diseases of Metabolism and Nutrition, by PROF. DR. CARL VON NOORDEN, American Editor, DR. BOARDMAN REED, New York City. E. B. Treat & Co., 1905.

This monograph deserves careful perusal, written by one of the most acute clinicians in Europe and embracing the sum total of the best information on the subject. It will be a revelation to physicians who have not kept informed in the disorders of metabolism and nutrition. The American Editor says: "Unfortunately, not all physicians realize that not only does every mouthful of surplus food add to the burdens of the digestive and excretory organs instead of strengthening the body, but every superfluous ounce of liquid ingested adds to the labor of the heart and kidneys, besides having to be for the most part forcibly extended by the stomach into the small intestine before it can be absorbed." Since Oertel in 1884 published his epoch-making book, "Therapy of Cardio-Vascular Disorders," we owe to him the revival of the idea of restricting the fluid intake. He proposed in cases of serious failure of compensation to dehydrate the organism by reducing the amount of liquids ingested and stimulating the elimination of water through the skin and the lungs.

The author advises sufferers from heart disease to drink sparingly, even when compensation is not disturbed; no more than from 1250 to 1500 cc. of liquid. Among the conditions in which Von Noorden advocates drink restriction may be mentioned gastrictasis, and in certain renal diseases, particularly in contracted kidney.

Von Noorden has shown that in most cases of chronic contracted kidney the elimination of urinary solids was not reduced when the fluid intake was restricted.

In diabetes insipidus, restriction of water gave contradictory results; in isolated cases the gradual reduction gives excellent results. Since the days of Plinus Secundus, this restriction has been recommended for obesity. In chlorotic girls the restriction of drink caused considerable increase in the specific gravity of the blood and serum; the percentage of hemoglobin and the number of red-blood corpuscles also rose.

The restriction of liquids in cirrhosis of the liver and in hemorrhages will appeal to all as a rational measure. STORCK.

Chemical and Microscopical Diagnosis, by FRANCIS CARTER WOOD, M. D. D. Appleton & Company, New York, 1905.

The value of the microscopical and chemical examination of the blood, and of the excretions and secretions as aids to diagnosis, is now recognized by every progressive physician. Together with the sphygmograph they play an important part with the stethoscope, clinical thermometer and ophthalmoscope. It is well that every practitioner who wishes to be honest to his patient and to himself should inform himself along these lines to the extent that his ability permits him.

Dr. Wood has given us a book in which the technique has been so simplified that physicians who have even a moderate laboratory training will, with some practice, be able to make many of his own examinations.

The morphology and special pathology of the blood receives ample and lucid explanation.

In the chapter on the urine will be found the identification of the different sugars found therein, thereby enabling the practitioner to distinguish between true diabetes and elementary melliturias. A simple apparatus for the electrolytic determination of lead in the urine is shown and its workings described. The treatment of feces, gastric contents and urine is accurate and abreast of our present day knowledge.

The volume contains many excellent illustrations essential to a work of this character.

Among the illustrations to be especially noted are those showing the malarial cycle, and which have been stained by means of the author's modified chromatic stain. The work is a fine specimen of the bookmaker's art. STORCK.

The Pharmacopoeia of the United States of America, Eighth Decennial Revision, Philadelphia. P. Blakiston's Son & Company, Philadelphia, 1905.

The Pharmacopœia of 1900 as it was known was made public June 27, 1905, and is official from September 1, 1905. We fear the time is too short for all physicians to make a fair acquaintance with the work, and for the pharmacist to make the necessary changes in the strength of potent tinctures and other pharmaceuticals as directed by the new pharmacopœia. It is extremely desirable that all physicians acquaint themselves with this excellent book, representing the erudition of a group of the best minds in medicine and pharmacy in these United States.

The history of the pharmacopœia is long and honorable. Conceived by Dr. Lyman Spalding, of New York City, in 1817, it remained till June 1, 1819, for the idea to assume shape. The committee then chosen formed into one which was adopted as the pharmocopœia o the middle district. The various medical colleges and societies except those from the Southern and Western districts took part in the forming of the first pharmacopœias. In the introduction to the new pharmacopœia we notice the following: "The Medical College of Ohio and the Medical Society of New Orleans approved the formation of a National Pharmacopœia.

The two pharmacopœias, after full revision, were adopted by the General Convention December 15, 1820, Dr. Lyman Spalding, chairman. The work appeared in both the Latin and the English languages. After a career more or less beset with ups and downs, the pharmacopœia has now reached its eighth decennial revision and equals that of any other country. While the pharmacopœia is not issued by the authority of the government, it is national in its scope, has the sanction of the government, and, in most states, is recognized as legal. The following will explain the composition of the revision committee: Representatives of the Medical Departments of the United States Army, of the Navy, of the Marine Hospital Service, of the State Medical and Pharmaceutical Associations, and all such incorporated colleges of pharmacy as shall have been in continuous operation for at least five years preceding the call of the President of the convention. Among the principal admissions were: Serum Antidiphthericum, Glandulæ Suprarenales Siccæ, Glandulæ Thyroidæ Siccæ, and some of the synthetics. It is to be hoped that suitable abbreviations will soon come into use for the last preparations, as their chemical titles are usually long. For the first time in the revision of the pharmacopœia is dosage given. Only the average approximate dose for adults is inserted. Concerning nomenclature, I quote: "The committee has adopted substantially that of the previous revision, notwithstanding the fact that some of them prefer the spelling used by some chemical writers, as morphin, quinin, sulfate, etc.; the dropping of the final e for the alkaloids and the halogens was not approved. It was not deemed wise to sacrifice this distinctive method." Some changes in the official Latin titles were made; for instance, instead of extractum aconite fluidum it will read fluidextractum aconite; acidum arsenosum is now arseni trioxidum.

Assay processes were introduced for eighteen drugs and their preparations.

The description of each chemical defines and limits the gross amounts of impurities in each article; for instance, writing of sodii nitras, the pharmacopœia reads: "It should contain not less than 99 per cent. of pure sodium nitrate (NO^2 O Na).

The potent tinctures are now of uniform strength, 10 per cent. This should be well borne in mind when prescribing. Tincture of aconite is now 10 per cent. instead of 35 per cent., as formerly; tincture of veratrum is now 10 per cent. instead of 40 per cent. The object of this change is to conform with other pharmacopœias.

The standard of 1 per cent. for liquid arsenical preparations and the long-established United States Pharmacopœia standard for fluid extracts (1 c. c. representing 1 gm. of drug) were both adopted by the International conference.

The metric system of weights and measures has been retained. Every physician should prescribe according to the new pharmacopœia, and in so doing it is best to use the following inscription, U. S. P., 1900.

This book, in conjunction with the work being accomplished by the Committee on Chemistry and Pharmacy, appointed by the A. M. A., should go far towards marking a new era in rational drug therapeutics in the United States. STORCK.

Handbook of Anatomy, by JAMES K. YOUNG, M. D., Second Edition. F. A. Davis Co., 1905.

This little book furnishes a brief synopsis of the many facts of human anatomy. The essentials of the subject are set forth clearly and concisely. The illustrations are numerous and good. It has our commendation as a handbook for students. DELAUP.

Publications Received.

P. Blakiston's Son & Co., Philadelphia, 1905.

Text-Book of Physiological Chemistry, by John H. Long, M. S., Sc. D.

A Manual of Organic Materia Medica and Pharmacognosy, by Lucius E. Sayre, B. S., Ph. M. 3rd edition.

Pharmacopeia of the United States.

Lea Bros. & Co., Philadelphia and New York, 1905.

Reference Hand-Book of Diseases of the Skin, by George Thomas Jackson, M. D. 5th edition.

Pathology and Morbid Anatomy, by T. Henry Green, M. D., 10th American edition, revised from 10th English edition, by W. Cecil Bosanquet, M. D.

Text-Book of Physiology, by Winfield S. Hall, M. D. Second edition.

William Wood & Co., New York, 1905.

Manual of the Diseases of the Eye, by Charles H. May, M. D. 4th edition.

D. Appleton & Co., New York and London, 1905.

Diagnosis of Internal Medicine, by Glentworth Reeve Butler, M. D. 2nd edition.

J. B. Lippincott Co., Philadelphia and London, 1905.

Therapeutics: Its Principles and Practice,, by Horatio C. Wood, M. D. 12th edition.

International Clinics. Vol. II., Fifteenth Series.

F. A. Davis Co., Philadelphia, 1905.

Hand-Book of Anatomy, by J. K. Young, M. D. Second Edition.

Color Vision and Blindness, by J. Ellis Jennings, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR AUGUST, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	10	3	13
Intermittent Fever (Malarial Cachexia)	5	1	6
Smallpox			
Measles			
Yellow Fever	210	7	217
Whooping Cough	2	1	3
Diphtheria and Croup	2		2
Influenza			
Cholera Nostras	1		1
Pyemia and Septicemia	1	1	2
Tuberculosis	40	40	80
Cancer	14	10	24
Rheumatism and Gout			
Diabetes	2		2
Alcoholism	7		7
Encephalitis and Meningitis	10	2	12
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	16	4	20
Paralysis	3	2	5
Convulsions of Infants	3	2	5
Other Diseases of Infancy	25	7	32
Tetanus	1	7	8
Other Nervous Diseases	1	1	2
Heart Diseases	41	29	70
Bronchitis	2	5	7
Pneumonia and Broncho-Pneumonia	6	5	11
Other Respiratory Diseases	3	1	4
Ulcer of Stomach			
Other Diseases of the Stomach	4	1	5
Diarrhea, Dysentery and Enteritis	21	8	29
Hernia, Intestinal Obstruction	4		4
Cirrhosis of Liver	6	3	9
Other Diseases of the Liver	1		1
Simple Peritonitis	1		1
Appendicitis	1		1
Bright's Disease	32	16	48
Other Genito-Urinary Diseases	4	1	5
Puerperal Diseases	4	5	9
Senile Debility	24	7	31
Suicide	3		3
Injuries	19	16	35
All Other Causes	5	15	20
TOTAL	535	200	735

Still-born Children—White, 23; colored, 28; total, 51.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 26. 1; colored, 27.91; total, 27.15.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**29.95**
Mean temperature	**83.**
Total precipitation	**3.95 inches.**

Prevailing direction of wind, southwest.

New Orleans Medical and Surgical Journal.

VOL. LVIII. NOVEMBER, 1905. No. 5

Original Article.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor shouid he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a Written order for the same accompany the paper.)

Gonorrhoeal Conjunctivitis in the Adult and the Infant.*

By Henry Dickson Bruns, M. D., New Orleans, La.

Acute gonorrhœal conjunctivis, ophthalmia, blennorrhœa, is the most violent of the conjunctival inflammations. It is a rare disease. Among 21,193 cases recorded at my clinic it was found but 157 times, .007+ per cent. These, however, comprise only the severe forms, or cases in which urethral gonorrhœa was also present. Could we have made a microscopical examination of the discharge in all cases of serious conjunctival inflammation, doubtless many other cases of milder type would have been discovered. In private practice the disease is still more uncommon. An eye inoculated with the gonorrhœal poison at first presents merely a marked conjunctival hyperæmia, with perhaps a few flakes of mucus in the lower cul de sac or a small collection of yellow discharge at the inner canthus. This stage is rarely seen; the patient, unless unusually intelligent, or well forewarned of his danger, fancies that he has merely some slight malady, "a cold in the eye," and does not seek the advice of a physician. Soon, about the third day after infection, the lids become swollen and brawny, their skin smooth, shiny and dusky; the upper lid overhangs the lower and can be raised only slightly and with difficulty and can not be everted. Tears clouded by secretion or tinged with blood squeeze themselves through the palpebral opening. The conjunctiva of the lids is thick, velvety, red, that of the ball chemotic. In another day or two the swelling of the lids subsides, their skin grows wrinkled and dull; while the discharge, at first scanty and pale, becomes profuse, creamy, greenish-yellow in color, runs down the cheeks and encrusts them and the lid surfaces. In this stage the chemosis of the bulbar conjunctiva disappears, but is succeeded by an angry-looking, dense infiltration, so that the cornea often appears to lie at the bottom of a red round-edged crater. It is now that we have to fear the much-dreaded corneal ulcer. This comes on as a light grey cloud of a portion of the cornea; from hour to hour the cloud deepens, gradually assuming a yellow hue which extends deeper and deeper into the cornea until perforation with escape of aqueous and prolapse of the iris takes place. In some cases the ulcer remains almost clear while the corneal substnce seems to melt away like ice in the sun until its whole thickness is penetrated. In others, worst of all, the whole cornea is strangulated and may pass in twelve hours from perfect transparency to a yellow poultice-like slough. At the end of another five or six days resolution sets in; the conjunctiva becomes less thick and red; the secretion less free and creamy—more flaky; the corneal ulcers begin to heal and assume a white, more and more china-like appearance, embracing at their centers the black more or less prominent or flattened (atrophied) remains of the prolapsed iris. Finally they are but white scars, occupying a varying extent of the distorted cornea, gripping the entangled iris (leucoma adherens); the conjunctiva slowly assumes its normal appearance. If the ulcers have been very extensive the opaque and weakened cornea may give way under the normal intra-ocular pressure and bulge far forward like a knuckle (staphyloma anterior), or if much of the iris has been incarcerated the anterior chamber may be obliterated (secondary irido-cyclitis), the front of the ball flattened and softening and phthisis bulbi close the scene. The disease is said to reach its height in about ten days and to run its course in from six to eight weeks. But it is evident that all writers are describing cases influenced by such treatment as they have been accustomed to employ. The disease is of so desperate a nature that no one is likely to be found bold enough, even were he so inhuman, as to withhold every effort to relieve for the purpose of studying its natural history. That all forms of treatment hitherto employed may have had marked influence upon the looks and the course of the disease, the observation of ophthalmia neonatorum, in which the interference is wont to be less severe and less incessant, and late developments in therapeutics give us grounds to suspect. Cases of gonorrhœal ophthalmia differ much in severity, varying from the pronounced type just described to one so mild as to be distinguishable from acute catarrh by the microscope alone. Often the stage of brawny swelling is absent. Usually but one eye is affected; where both are, the course of the disease is almost always much more advanced in one. This is due to the

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CAUSE AND MODE OF INFECTION.

The disease is caused by a diplococcus, the gonococcus of Neisser. The infection is never airborne, and no one now believes in metastasis, but the poison is conveyed to the eyes by soiled fingers, handkerchiefs, towels, etc. Usually the patient infects him or herself from a urethral or vaginal gonorrhœa. The knowledge of this danger is quite well diffused among the people, but the occurrence of cases shows that a warning from the physician cannot yet be considered unimportant. At times the source and mode of infection cannot be made out. Thanks to the exhaustive investigations of Piringer we now know that the virus may be attenuated either by dilution or by drying; that the more attenuated the longer the period of incubation and the milder the attack produced, and that by dilution to the one hundredth or drying for 36 hours virulence may be completely destroyed (Fuchs.) This, of course, accounts for the various degrees of severity of the disease and for its rarity in spite of the commonness of genital gonorrhœa. Juler says (third edition, 1904) that he knows of no instance of ophthalmia acquired by an individual from using a bath previously occupied by an infected person; nor have I any experience of strange or unusual modes of infection. I have heard of cases like that of Fuchs', in which an ophthalmia was acquired by a patient bathing a sore eye in his own urine, a remedy at one time by no means uncommon. We must be mindful not to be thrown off our guard, or to permit our just suspicions to be lulled by the age, social state or appearance of our patient. Wives may be infected by husbands and very little girls by careless mothers, nurses or other attendants. One of the saddest cases that ever came under my observation was one in which a girl of only 7 years had been infected with both gonorrhœa and syphilis by a negro nursemaid. Week's records (*Jour. Amer. Med. Ass'n., Vol. XLIII., p.* 1761) once observing an epidemic of gonorrhœal conjunctivitis affecting 22 inmates of a residential school for girls. Examination disclosed the fact that a number of the girls were suffering from a gonorrhœal vaginitis.

The habit of the gonococcus of penetrating deeply, even through the mucosa into the submucus connective tissue, is well known, and is the cause of the peculiarities of the inflammation (deep infiltration and suppuration) it produces. The diplococcus is found in the pus and epithelial cells and in the fluid portions of the discharge, but we must recognize also the rare occurrence of a general infection; for not only cases of gonorrhœal joint affections (g. rheumatism) and of inflammations of the iris have been seen by almost all observers of large experience, but others have recorded cases of comparatively mild conjunctivitis which they believed to have originated in the same way. Inoculation from pure cultures is difficult. Juler writes categorically in 1904: "No animal has yet been inoculated, but true gonorrhœa has been produced in the vagina of a woman after the twentieth culture." (*Loc. cit.*)

Age—Infection may occur at any age, though, naturally, it is commonest in youth. The ages of the 157 cases recorded in my hospital tables varied from 3 weeks to 70 years, but the average was 20 years.

Sex—Gonorrhœal ophthalmia is, for obvious reasons, commoner among men. Although the patients who attend my clinic are about equally divided by sex, of the 157 with gonorrhœal ophthalmia 114 were men and only 43, or 27 ± per cent., women.

Race—The disease is commoner in the black than in the white race, a fact that will cause no surprise to Southern physicians. About 40 per cent. of those who visit my clinic are of negro blood, but 53 per cent. of the 157 with gonorrhœal ophthalmia were persons of color. Among 3,480 cases of conjunctival disease in white persons there was .021 + per cent of gonorrhœal ophthalmia, while among 2,541 conjunctival cases in blacks there was .032 + per cent. of the same disease. Considering the almost universal prevalence of gonorrhœa among our negro population, their ignorance, carelessness and uncleanly habits, these figures are vehemently confirmatory of the belief that inoculation of the healthy conjunctiva with the gonorrhœal poison is by no means easy; otherwise gonorrhœal ophthalmia would be in this part of the world the commonest of diseases. I believe that its course is habitually milder in the black than in the white.

Symptoms—Besides the appearances already described, there is pain both burning and neuralgic; often the preauricular glands are swollen and tender; the patient looks ill and depressed, is feverish, listless and without appetite. If the case be a long one, toward the end he may be greatly debilitated as the result of pain, confinement, anxiety and grief.

Diagnosis—A typical case presents no difficulty, for no other conjunctival disease is marked by such pain, swelling, extreme injection and profuse discharge of purulent-looking matter. But there are many mild cases which can only be distinguished from acute conjunctival catarrh by examination of the discharge with the microscope.

Prognosis—The prognosis, formerly desperate, has of late years undoubtedly been growing better. Twenty years ago we thought ourselves fortunate to save one when both eyes had been attacked, and even the preservation of enough vision for perambulation and the reading of average type was regarded with satisfaction. Today the chance of escape without serious impairment of vision would seem to be by no means bad. The duration of an attack as given in the texts is from four to six weeks. During the ten years 1893 to 1903 only 39 cases were discharged from my clinic as cured. These under various plans of treatment, all methods of prima facie merit being faithfully tried, varied in duration from 7 to 510 days, the average being 40 days.*

In 1903 and 1904, 18 cases treated upon a later and better plan had a duration of from 11 to 90 days, an average of about 17 days.

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*This does not include 3 cases which, owing to chronic complications, dragged along for 17 or 18 months.

Owing to lack of room, very few if any of these cases were admitted into the hospital and the secretions were not often examined. But, at the worst, errors in diagnosis must have been exceedingly small.

All complications will increase the gravity of the prognosis. Scars (leucomata) even the very lightest and thinnest (nubeculæ) following ulcers of the center of the cornea will greatly reduce if not extinguish all useful vision. Deep, perforating ulcers leave behind dense scars in which a greater or lesser portion of the iris is entangled (leucoma adherens). If the scar involve a large proportion of cornea and iris, either bulging of the cornea (staphyloma anterior) or, in adults more probably, shrinkage of the eyeball (phthisis bulbi) from closing off of the anterior from the vitreous chamber, with or without atrophic changes in the ciliary and deeper portions of the uvea, close the scene. As the patient passes out of the dangerous stage we must not fail to impress him with the necessity of continuing his treatment until discharged, otherwise the disease is almost certain to pass into a chronic condition.

Treatment—But a short time ago this chapter of our knowledge might have been written without hesitation it is true, but with a gloomy diffuseness. We should have had to enumerate a large number of antiseptic solutions, all of them painful and none for that reason to be used in efficient concentration, with which the conjunctiva was to be flushed at inadequately frequent intervals. Much space must have been occupied and time consumed in the description of the technique of their employment and a thousand and one details of the making of applications and other procedures so well established and time honored as to be truly classical. Now, by the introduction of a single new remedy, all this has been changed; changed, and so greatly simplified, that a strong suspicion is growing up that to the very energy and thoroughness of the methods we once thought necessary were due many of the complications and sequellæ we chiefly feared. This remedy, the proprietary argyrol, is said to be a silver albuminate containing 30 per cent. of the metallic base. The discovery of the compound was no accident, but the result of a patient effort to construct by synthesis a salt which should possess all the virtues without any of the disadvantages of the time-approved silver nitrate. In all but one particular the success has been complete. In succeeding the authors must, it seems, have surpassed their fondest anticipations, for they have given to ophthamology an antiseptic which can be used in high percentages of concentration without producing on the delicate and sensitive tissues of the eye the slightest pain or irritation. An antiseptic not only equal to, but superior in its province to mercury bichloride in general surgery. What this must mean to our branch of medicine may be realized when we consider how minute a portion of any salt must come and remain in contact with any given point of the eye when we instill once or twice a day at most a dropperful of a 1 to 5,000 or 3,000 mercuric solution, or a 2 per cent. Labarraque solution, the strongest and most frequent applications of these irritating and highly painful substances which we have hitherto dared to make. It is true that of enzymol, the introduction of which constituted an advance in ocular antisepsis, 50 per cent. solutions can be used; but not without pain so decided that no patient could be intrusted to instill it frequently, and not without irritation so pronounced that no surgeon would venture to use it more than twice or thrice a day. The antiseptic action of enzymol, too, is indirect; it acts only by digesting away neurotic tissue, the pabulum of the septic organisms, and so destroying them by starvation. But argyrol in solutions of 10 per cent, or more, may be dropped into the eye without producing the slightest sensation other than that of moisture and continuously for two or three weeks before any symptoms of irritation appear. I first began using the drug in my hospital and private practice in the winter of 1903 and was at once struck with the great diffusibility of the solution. This is shown not only by its rapid spread over the anterior portion of the eyeball and the inner surface of the lids when a drop is instilled into the conjunctival sac, but by its prompt passage through the lachrymal drains into the nose; a fact to which my attention was soon called by patients, who felt it trickling into the throat and perceived the stain on their handkerchiefs upon blowing the nose. The tenacity with which the substance clings to the mucous membrane is evinced by our finding it in thin brown lines marking the folds and furrows of the conjunctiva hours after its instillation. It also stains the surface of clean corneal ulcers. One believes that it penetrates deeply the tissues, not only because of its influence on the gonococcus, which is known to burrow beneath epithelia, but also from the fact that a neutral solution poured into the conjunctival sac will become stained although no trace of the salt is visible and twenty-four hours may have elapsed since a single instillation. This may, of course, be due to invisible quantities retained upon the conjunctival surface or concealed in the lachrymal passages, but the number of times of irrigation may be repeated and the fluid still return stained would indicate that the argyrol is soaked out of the tissues. That this silver salt would possess strong antiseptic properties was already indicated by analogy and no one who has watched its action in purulent or muco-purulent conjunctivitis, on foul corneal ulcers and in eyes which have been operated upon and then bound up for two or more days, can fail to perceive its antiseptic value. In one respect, however, its astringent action, argyrol falls decidedly below silver nitrate and many of the other metallic salts. After from two to three weeks of constant use it not only ceases to astringe, but becomes actually irritating to the conjunctiva. These properties having been carefully observed there is no wonder that we came to rely more and more upon the substance possessing them in the treatment of gonorrhœal ophthalmia, where they are, of all others, the ones to be desired in a remedial agent. At first I made use of the weaker solutions and at intervals of three and two hours. But soon assured of the non-irritating quality of the remedy, I began rapidly to shorten the interval between instillations; perceiving that we had in these solutions a means of constant immersion in or irrigation with our antiseptic superior to any in use in general surgery, as the agent is less irritating to the parts immersed than any now in use by our confreres. This, it seems to me, is a point too little appreciated in our use of argyrol and, therefore, to be emphasized. Thus in the discussion of Dr. Myles Standish's excellent paper before the Ophthalmological Section of the American Medical Association, a paper to which I shall frequently refer (*Journ. Amer. Med. Ass'n,* Dec. 17, 1904), Dr. Frank C. Todd, of Minneapolis, in maintaining the superiority of protargol, speaks of using the two drugs in solutions of 50 per cent. in glycerin from one to three times daily. Such a mode of using argyrol is utterly inadequate to obtain the effect sought and the extremely irritating menstruum chosen (glycerin) sacrifices one of the most valuable properties of the remedy. Dr. John C. Weeks, of New York, speaks of using argyrol in 35 per cent. solutions "about every two hours;" Dr. Hiram Woods, of Baltimore, of using a 25 per cent. solution every third hour and a 50 per cent. solution twice a day. Dr. Standish himself describes his routine use of the solutions to be from once every hour to once every four hours in ophthalmia neonatrum; as he mentions no difference he presumably employs them in like manner in the adult. I am firmly persuaded that the great advantages of the treatment with argyrol cannot be reaped in this way. Dr. Standish (*loc. cit.*) very wisely points out that the repeated manipulation of the eyes in the attempts to make thorough applications of this or that remedy, or to remove every shred of pus from the conjunctival sacs, is not only futile but injurious; for, no doubt, during such manipulations we injure the corneal epithelium and open the way to the production of the much-dreaded corneal ulcer. He also clearly indicates the superiority of the dense argyrol solution, which, sinking to the bottom of the sac, floats up and out through the palpebral aperture the masses of clinging secretion. Nearly all the participants in the discussion concurred in these views and yet nearly all spoke of very frequent cleansings with boric or other practically neutral solutions. Now, basing ourselves upon all these considerations, the plan of treatment pursued in gonorrhœal ophthalmia in our clinic, from the winter of 1903 to the present time, is: As soon as the case presents itself the free instillation of a 10 per cent. solution of argyrol *every fifteen minutes day and night* until suppuration has ceased is ordered. No violence is required to do this. To the patient or his attendants is demonstrated how to draw the lids carefully and gently apart and allow the solution to fall into the conjunctival sac from a medicine dropper. The excess of fluid and the pus carried out with it are wiped from the face with bits of moist absorbent cotton. No other collirium is used and no further effort to remove pus from the conjunctiva is made. Under this "immersion treatment," as I have called it in lecturing to my students, pus formation is checked and the case removed from the dangerous category in from 48 to 72 hours. Not only is suppuration soon checked, but I have observed under these free and frequent instillations of this concentrated and non-irritating antiseptic solution an absence of great swelling and brawniness of the lids*, of infiltration and elevation of the conjunctiva about the cornea; of evidence of much suffering; and of infiltration and ulceration of the cornea. While all this is true and lifts a load of anxiety from the mind of the surgeon, nevertheless if no remedy in addition to the argyrol is employed we soon observe a tendency on the part of our cases to remain stationary and gradually to assume a chronic condition. Although suppuration has ceased the conjunctiva keeps thick, uniformly red, with a dull, slack, lifeless look, peculiar but difficult to describe. This is due to the feeble astringency of argyrol, and, it seems, to its actually irritating the conjunctiva when too long and frequently applied. If now, suppuration being virtually at an end, we begin cautiously to decrease the frequency of the argyrol instillations, lengthening the intervals to an hour, two hours, etc.; and if at the same time, at each daily visit the lids are carefully everted and a silver nitrate solution of from one-half to five grains to the ounce* is gently applied to their mucous surfaces, either by a cotton swab or by allowing it to flow over them from a medicine dropper, being as carefully washed off with clean water, the flabby conjunctiva will rapidly take on a more healthy look, its thickening will disappear and the eye begin to assume a natural appearance†. It will be noted that this careful application of silver nitrate, but only after pus formation is checked, is the one manipulation to which the eyes are subjected. The length of time before the patient can be discharged cured will vary with the severity of the attack and the constitution and condition of the patient. We must not, however, on any account be flattered into discontinuing treatment prematurely; first, on account of the tendency of the disease to assume a chronic form, and, second, because certain facts make it probable that it may, in the eye, as we know it does elsewhere, now and then subside into a latent state if not entirely stamped out by thorough treatment. Not long since I saw two cases with leucomata corneæ, the result in one certainly, in the other in all human probability, of attacks of gonorrhœal ophthalmia of more than a year ago. In the one a slight operation was performed upon the lid and for some days did well, when suddenly the leucoma became a virulently infected ulcer, and the infection, presumably, travelling along the adherent iris rapidly produced a panophthalmitis; in the other exposure to cold and wet lighted up with equal promptness and severity a cyclitis, which, in spite of every effort to extinguish it, quickly destroyed the only useful eye. As to the strength of the argyrol solution employed, I have come to prefer the 10 per cent. because it has seemed to me: First, less irritating than the stronger when long and frequently used; Second, less viscid and more diffusible; Third, more penetrating; and I have feared to set osmosis from the tissues toward the solution should it be made too dense. Finally I have failed to obtain either better antiseptic or detergent effects from the denser solutions. However, all this cannot be taken as yet definitely established and should be the subject of continued and close observation.

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*It must be said, however, that my clinic being mainly an ''out-service'' and a large percentage of the patients negroes, the earliest stage of the disease, in which swelling and brawniness are conspicuous, is seldom seen.

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*The weaker solutions at first until we see how they are borne, then the stronger and finally the weaker again, as the conjunction becomes more and more normal.

†I have lately watched with especial care three cases treated by this "immersion plan" on account of the great severity of the attack. In two the bacteriological examination was positive, in one negative. In this last however, the clinical evidences, among them the presence of urethral gonorrhoea and the prompt appearance of deep and long marginal corneal ulcers, could leave no doubt in the mind of any observer. In the first case pus ceased to form on the 3d, in the second on the 4th, and in the third on the 3rd day of the treatment. The first, a "dago," at once disappeared from the clinic upon cessation of the discharge, the second was kept under the infrequent argyrol and daily silver nitrate treatment for many days, the third for a few days, when his corneal ulcers were entirely healed. The second of these cases was an unusually virulent one, and presented on the upper lid a deep infiltration beneath the slightly eroded conjunctiva a deep, pale infiltration like the bacon fat infiltration of diphtheria, the like of which I have never seen before.

From the beginning of 1893 to the end of 1902 36 cases* were treated until discharged by the various methods in vogue with an average duration of 39.33 days. Since 1903, when we began to use argyrol, one group of 11 cases has been treated with an average duration of 14.5 days, and one of 7 cases† with an average duration of 23 days.

In Dr. Standish's paper (*loc. cit.*) he presents the following valuable table compiled from his records of cases treated in the Massachusetts Charitable Eye and Ear Infirmary:

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*Three cases which were allowed to drag on a chronic course of from 17 to 18 months not included.

†In 1904: These were 5 whites, 3 negroes, 4 mulattos; 8 male and 4 females. These seven stayed on until discharged cured, but 5 never returned after the first visit.

Results of treatment of Gonorrhœal Ophthalmia with protargol and argyrol:

Per Cent Used	Entered with Clear Cornea	Discharged with Clear Cornea	Entered with Corneal Lesion	Discharged with leucoma	Lost or total leucoma.
Protargol 10	18	14	10	13	1
" 20	12	5	6	10	3
" 30	1	1	....	....	....
" 40	1	1	....	..	....
	32	21 43+%	16 33+%	23 47+%	4 8+%
Argyrol 15	2	2	....	....	....
" 25	12	8	7	6	5
" 50	9	6	7	7	3
	23	16 43+%	14 37+%	13 35+%	8 21+%

Certainly these figures give no weak testimony to the efficiency of argyrol when we note that while the percentage* of those who entered with corneal lesions and were treated with argyrol is larger than in the cases treated with protargol, yet the percentage of those discharged with clear cornea is the same in those treated with argyrol as in those treated with protargol while the number discharged with leucoma is less. It is true that the number of eyes lost among those treated with argyrol is almost three times as great as among those treated with protargol; but this many be explained, perhaps, by the fact just noted that more of those who were placed under the argyrol treatment had lesions of the cornea when first seen, while among so small a number the presence of a few extra bad cases would make a great difference in the percentage. Who can say that had the argyrol been instilled every fifteen minutes or half hour during the first 36 hours, instead of from once every hour to once every four hours, as we gather from Dr. Standish's paper was done, the results would have been the same? The crowning superiority of argyrol over protargol is its painlessness and freedom from irritating quality, but if we fail to push this advantage to its logical conclusion, as is done in the "immersion treatment," we fail entirely to obtain the maximum of benefit. Unfortunately no exact comparison can be instituted between Dr. Standish's figures and mine. My tables fail to note the number in whom there were corneal lesions upon admission to the service and on discharge. All of his cases were admitted into the hospital and properly attended by skilled nurses; while mine, almost without exception, were treated as out patients, came to the clinic once daily, and either nursed themselves or received only such assistance as their unskilled relatives or friends could render. Under such circumstances it is impossible to keep control of the patients and be able to give the exact percentages of the number discharged cured, improved or worse. Many only come once or twice and are then lost sight of. Thus of 169 cases recorded at my clinic from January, 1893, to January, 1905, only 57 remained until discharged cured, 3 left "worse," and the remainder, 109, "never returned." Such figures cannot, of course, support positive conclusions; but that the 21 patients who, during the past two and a-half years, submitted themselves fully to the treatment by immersion in 10 per cent. argyrol solution should have done so well under such adverse conditions, certainly justifies a strong—even an enthusiastic—hope for the future.

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*I have added the percentages in the table here printed.

OPHTHALMIA NEONATORUM.

Ophthalmia neonatorum is acute purulent conjunctivitis in the infant. The appearance, symptoms, course and complications do not differ materially from those of the disease in the adult. As in gonorrhœal opthalmia in grown persons, so in the infantile affection the cases vary in severity. But while the swelling of the lids may be marked the brawniness is not so great, nor is the infiltration of the bulbar conjunctiva conspicuous and dense. Ulceration of the cornea does not so readily occur and an incipient infiltration is more likely to take a favorable turn and to clear up under appropriate, careful treatment. One may often observe the corneæ of these little patients perfectly bright and clear after having been bathed for weeks in thick, ugly looking pus. This is probably due to the activity of cell life and all processes of growth and nutrition in the very young; but, as I have said, I must think that it is in part due to the impossibility of subjecting patients of such tender age to the full vigor of the treatment we have thought necessary in the adult. When ulceration, with or without perforation, does occur, we have the same sequelæ, leucomata, staphylomata, phthisis bulbi, that we see in the adult.

By reason of the babe being unable to help itself, one feature of the disease, and probably a distressing one, is accumulation of the secretions behind the lids. The edges of the lids become agglutinated, or owing to their swelling the upper one cannot be raised and pus and tears are retained under pressure. When the lids are drawn apart by the fingers of the observer the pent up matter gushes forth and may spurt up some little distance. The physician should bear this in mind and nurses should be warned of the danger, lest bending too close over a patient they receive some of the discharge in their own eyes. This disease is said to cause more than 10 per cent of the blindness of the world, but in my practice it cannot be called common. In eleven years, among 21,193 cases, it was recorded 230 times, rather more than 1 per cent.

Cause—By general acceptation the name ophthalmia neonatorum is reserved for cases of purulent conjunctivitis in which infection has taken place during birth by entrance into the eyes of the infant of a discharge contained in the genital tract of the mother; or by the inoculation of a portion of such discharge, clinging to the skin of the child, during its first bath. Instances are recorded of infants born with the disease, and here infection is supposed to have been intra-uterine, but none has fallen within my experience. Undoubtedly the gonococcus is the active agent in the vast majority of instances. How this fact is compatible with great variability in the severity of attacks has been explained when speaking of gonorrhœal ophthalmia. Certain very mild cases are said to be due to non-specific vaginal discharges in the mother, but actual purulent conjunctivitis in infants which impressed me as not dangerous it has seldom been my lot to see. Of course, examination with the microscope is the only means of absolute certainty, but we should remember that no single microscopic examination is infallible and that all negative evidence is haunted by possible errors. Nor should we forget that a seemingly mild attack in one subject may be the cause of a most violent one in another. Doctor Myles Standish, (*loc. cit.*) in ninety-one cases in which the discharge was microscopically examined in every case, found the gonococcus present in 70 + per cent.

The disease is usually observed during the third day of life, but it is said occasionally to occur as early as the first twelve hours.

It seems to be universally agreed that the latest date of manifestation is the fifth day, and that if further postponed inoculation has been brought about by soiled fingers, linen, sponges, etc., as in ordinary cases in adults; of course auto-infection is here almost inconceivable. Such cases should not be called ophthalmia neonatorum, and in my recorded cases they are never so called. Thus my hospital records show cases of gonorrhœal or purulent ophthalmia in children of 2 weeks, 1, 1 1-2, 2 and 3 years old. This is a matter of some importance; for in no science more than in medicine is it desirable to preserve the ability to express slight shades of meaning by the careful use of words. Not only are exact thinking and exact knowledge favored by exactness in the terms of our diagnosis and their connotations, but this may prove of social or even medico-legal importance. For an unqualified diagnosis of ophthalmia neonatorum implicates the mother and therefore, usually, the father, while a gonorrhœal ophthalmia occurring at 2 or 3 weeks of age may be due to a careless relative, friend or nurse, or even, it is conceivable, physician.

Age—By necessary implication then, the disease only occurs in infants, and, it may be repeated, the name should be restricted to cases in which infection has taken place before, during or immediately after birth. In private practice, therefore, the physician will be called to see these cases on or before the fifth day of extra-uterine life. But not so in hospital practice; our hospital records tell a pitiful story of ignorance or neglect, and emphasize the necessity for further effort by physicians, in our part of the world at least, to instruct mothers and nurses as to the extreme danger of the disease and the necessity for prompt treatment. Indeed, that this is true of all diseases of the eye, is one of the saddest facts with which the ophthalmic surgeon to a large hospital is kept constantly impressed. The miserable words: Too late! must be forever on his tongue. If the 230 cases of ophthalmia which have been recorded in my hospital service during the past eleven years be considered by groups according to the years in which they were seen, we find the age of the younger patients when brought for treatment to vary from three days to two weeks, and of the older from five weeks to nine months, the average age of all the groups being 25 days. The reason assigned for the long delay in presenting the child for treatment was almost always that the midwife in charge, or occasionally some officious maternally experienced person, had said that the baby had "only a little sore eyes," which could soon be relieved by domestic medication. The cause assigned by the mentor being either that etiological drudge of all work, a common cold, or the still more absurd popular superstition, too early exposure of the eyes to light. Were the effects not so lamentable, the remedies employed by the *sage-femmes,* or equally sage female advisers, might be called ridiculously futile, varying as they do, according to intelligence and cleanliness, from boracic acid wash, dew-water, or breast milk, to tea leaf poultices and other more filthy applications. These considerations excuse the law of many States requiring parents or midwives having the care of new born infants to notify a competent medical practitioner upon the first appearance of redness, swelling or discharge about the eyes of their charges. The advocacy of such a statute is not incompatible with disapproval of sumptuary legislation when we remember the number made blind by the disease, a large percentage of whom are sure to become burdens upon the State in her asylums and almshouses. By such a measure the commonwealth but endeavors to protect herself and her taxpayers, doing all in her power to eradicate the evil. It may well be argued that the carelessness or ignorance of our neighbor cannot justly be reason why we should all have to support his helpless child during the rest of its natural life.

Sex—We can imagine no reason why the disease should prevail more in one sex than in the other. However, de Schweinitz, in his text book, states that boys are oftener affected than girls. This is not true of my cases. Of the 230, 114 were boys and 116 were girls, an inconsiderable difference. In 1904, of 18 cases 7 were males, 11 females.

Race—Owing to the general prevalence of gonorrhœa among our negroes, we would naturally suppose ophthalmia neonatorum to be more common among them than among the whites, but my figures do not bear out the supposition. Not only is it not more, but it seems, in fact, rather less prevalent than among the whites. While persons of color form about 38 per cent. of all my recorded cases (21,193), we find that but 34 per cent. (80) of the 230 infants with gonorrhœal ophthalmia were of negro blood. The percentage of whites with this disease among all the whites treated during eleven years, 13,043, was .011 +; while the percentage of blacks with the disease among all the blacks treated during the same period, 8,096, was only .0098+. Again, the percentage of ophthalmia neonatorum among all the whites with diseases of the conjunctiva, 3,480, was .043+, while the percentage of infants of the other race so afflicted among all those of that race with conjunctival disease, 2,541, was only .031+. In 1904 the percentage of ophthalmia neonatorum (13 cases) among all the whites with diseases of the conjunctiva, 219, was .059+, while the percentage of the disease (5 cases) among all those of negro blood with conjunctival disease, 344, was only .014+ per cent. These figures seem to leave no doubt that in this city and its neighborhood ophthalmia neonatorum is more common among the whites than among the negroes. They are emphasized when it is remembered that the percentage of blacks with all forms of conjunctival disease (.42+) exceeds the normal percentage of blacks (.038+ per cent) among all those who visit my clinic. Is it possible to explain this on the supposition that the negroes, more ignorant and indifferent, are more careless in bringing their afflicted children to the hospital? I doubt it. Ophthalmia neonatorum is a horrid enough disease to impress even a negro mother, and they are usually up and about soon after child-birth. But, grainting this, I think it would probably be offset by the number of very poor whites who would take their children to private offices, straining a point to secure what they fancy to be the superior care thus obtained.

Symptoms—The appearances of gonorrhœa of the conjunctiva have already been sufficiently described. Of course, no subjective symptoms are to be elicited in ophthalmia neonatorum.

Diagnosis—This, the time of onset and the look of the disease being considered, presents no difficulty. The impossibility of an etiologic diagnosis in mild cases without the aid of the microscope, and the advantage of such certainly in every case should be constantly borne in mind.

Prognosis—In promptly and properly treated cases the prognosis may be said to be absolutely good*. Had this been written yesterday I would have been able to say that in more than 20 years' experience I had never seen ulceration, perforation and prolapse occur when the corneæ were clear at the time the case was presented for treatment. A day or two ago I saw a large ulcer develop on the cornea of a well nourished infant affected with severe gonorrhœa of the conjunctiva (microscopical diagnosis) after two days of treatment. The mother, a weak and foolish woman, was wholly without assistance in carrying out the treatment at home, and evidently failed to get any of the collirium prescribed (10 per cent argyrol) within the lids. In uncomplicated cases the duration may be safely put down at from two to four weeks, according to the severity of the attack. In 152 cases which remained under treatment until discharged, the average duration was a trifle over 24 days. In 18 cases treated during 1904 the duration was from 10 to 74 days, and an average of 25 days. Complications of all kinds, of course, lengthen the duration and increase the gravity of the prognosis. In neglected or improperly treated cases we will be called upon to prognosticate the effect upon vision of the scars (nubeculæ, leucomata) resulting from corneal ulcerations. In the main the prognosis will depend upon the size of such scars and their position; the larger and the more central the scar the greater the interference with vision* Two features always indicating a sinister course are a tendency on the part of the scar to bulge forward (staphyloma) or the involvement of a large portion of the iris in a corneal scar (leucoma adherens). The staphylomatous process once begun, the hope of checking it will be small. If all, or almost all of the pupilary portion of the iris be involved in a leucoma, especially if it be extensive, staphylomatous or atrophic processes, either essential or following in the wake of iridocyclitis, will destroy the globe; or so small an amount of clear cornea and free anterior chamber will be available that iridectomy will be either useless or impossible. A small perforation at the center of the cornea may lead to contact of the central portion of the anterior capsule of the lens with the bottom of the ulcer, until repair having taken place, the aqueous reaccumulates and the anterior chamber is reformed. In this case lymph is deposited on the anterior capsule and the lens cells immediately underlying proliferate and change and an anterior polar cataract is formed. This will remain through life, although the corneal opacity following the ulcer may have become invisible. Fuchs asserts that a fine fibre may sometimes be seen extending from the site of the corneal opacity to the polar cataract; also that central perforation of the cornea is not necessary, but the mere contact of the anterior lens capsule with the inner surface of the cornea after any perforation is enough to bring about the cataract, but such cases I have not seen. These anterior polar cataracts are most common after intra-uterine perforations of the cornea.

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*It is almost needless to add that this statement presupposes at least a fair state of general health and nutrition. As in all diseases in which the cornea is threatened low vitality means great danger. In marasmic infants, in those in whom assimilation is going on badly, gonorrhoeal ophthalmia almost always dooms the eye to destruction.

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*The depth of the ulcer and the density of the resulting scar also exercises an influence.

In all instances of simple nubeculæ or leucomata in infants or young children prognosis should be guarded as in the course of years, especially if the child be healthy and well nourished, clearing of the cornea to be a surprising degree often occurs. For this reason, even more than in the case of adults, we must exhaust all our efforts to save even the smallest remnant of the cornea; for no one can tell that a wholly gloomy condition of blindness may not be, by a well timed and well placed iridectomy be converted into the ability at least to perceive large objects and to guide oneself about. Even after extensive perforation and escape of the lens, if only a sufficient portion of clear cornea remain the prognosis may be decidedly affected by such a possibility (iridectomy or iridotomy). All this *mutatis mutandis* is as true of these complications in the adult.

Treatment—The treatment in the adult having been discussed at length little remains to be said here. In all cases I should have the 10 per cent. solution of argyrol freely instilled every 15 minutes during the day and every half an hour during the night. Pus should be flooded out of the eye with the solution and wiped, with the excess of the drug, from the cheek with pledgets of moist absorbent cotton. This must be continued for from 36 to 48 hours, by which time all pus formation will have ceased; the intervals can now be lengthened, and as the astringent action of argyrol is small, we should begin the application of the silver nitrate solution to the carefully everted lids at each daily visit. The lids will now be much more easily everted than before and the chances of producing lesions of the corneal epithelium greatly reduced. Should this occur, pus formation having been stopped, the risk of infection and the formation of a corneal ulcer is much lessened.* Among our poorer patients the nursing will have to be divided among several relatives, all of whom will have to be instructed at the daily visit in the method of making the instillations. Among the richer, one or more trained nurses should be employed. Silver nitrate should be used by the surgeon only.†

When a case of ophthalmia is first seen the corneæ must be carefully inspected and a note made of their condition. This is a matter of high importance, for it is no common thing to hear the mother of a child who comes to us seeking removal of leucoma assert that "the strong medicine Dr. So & So used left these scars on the eyes." To make such an examination properly the nurse must be seated on a chair placed at right angles to the surgeon's; she places the infant across her lap and holds its hands while its head is gripped between the knees of the surgeon. The lids are then gently drawn apart, with the fingers if possible, but most cautiously with retractors,‡ if necessary. The eyeballs will be discovered strongly rolled up and only a small portion of the corneæ will be visible; but the superior recti will grow weary before the fingers of the surgeon and as the eyes slowly turn down the corneæ can be narrowly scrutinized. Should pus obscure the view it should be flooded out of the eye with the argyrol solution. If the corneæ are found to be infiltrated, hazy or steamy, or actually ulcerated, the condition should be demonstrated to the parents and the fact that the ulcerations will be almost sure to leave white scars "on the front of the eye" should at once be plainly explained. Whoever is to have charge of the nursing should be made to observe carefully every detail of the instillation of the solution and of the cleansing of the eyes, and the necessity of the co-operation of two persons in these proceedings must be enjoined. It is well that a parent or a close relative of the little patient and the associate or assistant of the surgeon should be present at this first examination, for obvious reasons.

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*For this astringent action silver nitrate solutions of from 1-4 to 1-2 per cent (1 to 2 1-2 grains to the ounce) seem amply strong. Indeed, I have not found these necessary—as I have in adults—in all cases in infants. Often the frequent use of a borax-boracic-camphor water wash is sufficient; but in all severe cases and in all in which I suspect inefficient or careless nursing I make the silver nitrate application once a day, but not until secretion of pus has been checked if I can avoid it.

†It will be noted that this careful application of silver nitrate, after pus formation is checked, is the only manipulation to which the eyes are subjected.

‡When no retractor is at hand one may be extemporized by bending down the loop end of a common wire hair-pin.

I have never found it necessary to do canthotomy or to make use of cold compresses in these cases; nor have I seen anything but good results from bringing infants of the tenderest age daily to the clinic or the surgeon's office, if well protected, even in the most inclement weather of our winters. A long service in an institution in which these cases have to be treated as "out patients" has given me exceptional advantages for this observation. As I have intimated, ophthalmia neonatorum, if the case be seen before the cornea has been damaged, will recover in the majority of instances under any treatment by which the eyes are kept cleansed from pus. The average duration of 118 cases, which were treated until discharged cured by the application of the silver nitrate (usually 1 per cent.) once daily at the clinic, together with frequent cleansings with neutral solutions, solutions, of formalin and of late years, solutions (1 to 50) of Labarraques solution, was 27 days. In 1901 and 1902 the silver was used in the same way, but frequently instillations of enzymol, 50 per cent. were made at home and the average duration of 17 cases treated until discharged cured was 17 days. In 1903 the silver nitrate was used once daily and argyrol 10% was instilled every two hours, or rather more frequently, and 17 cases treated until discharged cured had an average duration of 15 days. In 1904, silver nitrate being used in the worst cases only, a weak zinc sulphate wash (gr. 1-4 to ℥;) being often used after pus formation had ceased to reduce the conjunctivitis, and the 10 per cent argyrol solution being instilled at home every half hour all the 18 cases seen during the year were cured in 25 days (average). All secretion of pus was stopped, on an average, in 7 days. Many of these were very severe cases, as this record shows, and in three the cornea was infiltrated, but did not become ulcerated, and all were discharged without scars. But it is not from this slight shortening in the average duration of cases that I derive my favorable impression of argyrol. The more I use the drug the deeper becomes the impression that these cases recover more quietly, more smoothly, so to speak, with less violence on the part of the attendants and less evidence of pain or even discomfort on the part of the little patients.

The doing away for the need of dragging apart of lids, of wiping or syringing out pus, of introducing retractors and of everting lids is a great gain. To any one but an expert, and one at that by temperament, patient and gentle, the eversion of the lids of a wee, struggling baby is by no means easy, and where perforation is threatened the difficulties and dangers are increased many times. On the other hand the ease with which the lids may be drawn slightly apart and the argyrol solution dropped into the opening, often without awakening the infant from its slumber, is very gratifying; the rapidity with which pus formation ceases in the argyrol-soaked conjunctiva is to one long accustomed to the old—and one might almost say obstreperous—method, amazing. The filling and keeping filled of the tear passages with the antiseptic is another evident advantage, which I omitted, I believe, to mention while discussing the use of argyrol in gonorrhœal ophthalmia in the adult. While these observations were in progress it was pleasant to find in the paper of Dr. Standish, so often referred to, an encouraging agreement of results.

"Two years ago," he says, "in a paper read before the New York County Medical Society, I made a comparison of results obtained in cases of ophthalmia neonatorum treated by nitrate of silver and protargol. I was able at that time to find 50 cases in the records of the Gardiner building in which silver nitrate had been the agent relied on. Of these 50 cases, there were three that had clear corneæ on admission, which subsquently developed ulceration of the cornea sufficient to interfere with vision. This showed 6 per cent of unsuccessful cases. I found on the records at that time 150 cases in which protargol was the only remedy used. Among this number were also three admitted with clear corneæ, which subsequently developed ulcers that greatly injured or destroyed sight. This gave 2 per cent of unsuccessful cases. The protargol solution used was increased from 4 per cent in the beginning to the habitual use of a solution of 20 per cent and, in the last 50 cases treated, no baby with clear cornea on admission had any corneal complications."

"The 50 cases in which nitrate of silver was used were in the hospital an average of 23 1-2 days, and the last 50 cases referred to were in the hospital an average of 16 1-2 days, making a difference of one week in the time of treatment. Since that paper was written, argyrol as the local application in these cases has been largely used in the Gardiner building, and I have been able to find on the records 64 cases of ophthalmia neonatorum, with gonorrhœal infection, which entered with clear cornæ in which it was depended on as the principal agency. All of the 64 cases were discharged with clear corneæ, and the average stay in the hospital was 18 2-3 days. I also found on the records 9 cases in which it was noted on entrance that the cornea was 'hazy,' in only one of which did any ulceration follow. These cases, although naturally more serious, only remained in the hospital an average of 22 days. During the same period 9 cases entered which already had corneal lesions, in only one of which was the eye lost. From these cases it will appear that either of the modern silver salts gave much better results than was ever obtained from the use of nitrate of silver."

Dr. Standish goes on to say that the lids were washed once every half an hour and the argyrol instilled at intervals of from every hour to every four hours. In no case did he find it necessary to apply cold or to do a canthoplasty. It will be seen that Dr. Standish's experience with his interned and carefully nursed cases was about the same as mine with my outcases, who had no more careful nursing than their poor relatives were able to give.

The application of cold save as a grateful pain-relieving measure in adults, I have long abandoned. Could we reduce the temperature of the front of the eye to such a degree as to lessen the activity of the cocci, we might well dread its effects upon the nutrition of the eye, but this the experiments of Dr. Standish has shown it is impossible to do. My impression is that cases do better without it; the macerating effects of wet cold have appeared to me harmful.

The simple fact that protargol is painful and to an extent irritating and cannot, therefore, be used ad libitum, seems to me to dispose at once of its claims of usefulness in comparison with argyrol.

Prognosis—The experiments of Crede with 2 per cent solution of silver nitrate and his banishment of ophthalmia neonatorum from the Leipsic Lying-In Asylum by careful bathing of the infant and the instillation of this solution, is now a twice-told tale. If it were universally adopted by obstetricians ophthalmia neonatorum would soon become an almost unknown disease. "There is, perhaps, no other disease in which the vigorous carrying out of prophylactic treatment would afford more gratifying results," says Fuchs, and he estimates that if blenorrhœa were thus made to disappear there would be in Europe alone at least 30,000 fewer blind people. And yet, because the infant cries out and they fear to be disagreeable to their patrons, physicians, incredible as it seems, persist in abstaining from its use! Whether the painless argyrol is capable of taking the place of the painful nitrate thus removing the last shred of objection to this invaluable method, only long extended experience in our hospitals and lying-in institutions* can in time inform us.

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P. L. Thibaut, M. D., Chairman.

DISCUSSION OF DR. BRUNS' PAPER. (See Page 355.)

DR. E. W. JONES.—We see a great many of these cases, and also prescribe a ten per cent. solution of argyrol, and we recommend that these people use it every hour, and possibly every two hours. They do not always follow our instructions, for one reason or another.

DR. DOWLING.—I have been using argyrol for some time, and I have not been getting results until recently when I learned something about the way of using it, and am now getting better results.

In the past twelve months I have been unfortunate to lose three eyes. In those cases their eyes were not watched, the medicines were not applied. It is very difficult to get people to understand the importance of following your instructions.

DR. R. W. SALTER.—I want to emphasize a fact, which Dr. Bruns has emphasized, that argyrol can be given and used by the laity without any danger to the eyes. In cases where there is excessive pus formation argyrol should be used as often as every fifteen minutes.

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*And on the part of a multitude of private practitioners.

DR. BRUNS, in closing—You can never get the astringent effects from argyrol that you can from nitrate of silver. Having got the eye free from pus and kept it so one or two days, turn back to our old friend, nitrate of silver. Argyrol will not reduce the baggy and thickened conjunctiva. If you use argyrol vigorously for two weeks or longer, it will produce an irritation that you will have to combat.

Fracture of the Lower Extremity of the Radius.

By C. J. GREMILLION, M. D., Alexandria.

I feel that I need no excuse for bringing this practical subject before you for discussion. The frequency of these fractures, ten per cent., according to Malgaigne, the difficulty in diagnosis, and the frequent deformity they occasion, make them of extreme interest to all of us.

The time at my disposal is so short, I shall confine my remarks to fractures at the classical spot or "Colles' fracture."

Ponteau was the first surgeon who wrote about fractures of the lower extremity of the radius, and he was the first to describe its symptoms definitely and positively. This contribution to medical literature was entirely ignored, and neither Boyer nor Desault profited by this essay.

Dupuytren, taking up the study of Ponteau, proved by pathological anatomy the correctness of the principles of his teaching. Dr. Colles, of Edinburgh, in a contribution on the subject in 1814, brought the subject clearly and forcibly before the medical profession; so much so that to this day the fracture bears his name But to no other man is the profession more indebted for the proper treatment of this fracture than to Dr. E. M. Moore, of Rochester, N. Y. His treatment, and many of the researches he has made, are so interesting that I will take the liberty of quoting him often in this paper.

By Colles' fracture we understand a fracture of the lower extremity of the radius, generally transverse, about three-eighths to three-fourths of an inch above the distal end and with displacement of the distal fragment backward, and usually outward, and frequently with corresponding displacement of the wrist. Moore says: "The cause of this fracture is a fall upon the outstretched palm. Thus the bone is broken, and the cancellated tissue at the expanded end of the radius has its surfaces somewhat interlocked and the hand usually a little turned to the radial side of the forearm. The hand, of course, follows the radial fragment, and when carried back makes a curve of the anterior aspect of the hand and semi-extended fingers, which has given to it the name of the 'silver-forked fracture.' I think, however, this description is far short of that necessary to elucidate the varying conditions direct and supplementary to this accident. The fall, of necessity, has always a varying quantity of force. It may be just sufficient to produce a fracture, as described by Colles. But it may be a little more. It is obvious that when the bone is broken the tissues attached to the ulna must bear the strain. These are the internal ligament and the triangular fibrocartilage. On examining the carpal end of the ulna we find a smooth, articulating surface, flanked by a dull-pointed, bony projection at its internal border, known as the styloid process. From this the internal lateral ligament takes its rise and is inserted in the carpus. At the base of this process, and between it and the articulating surface at the end of the ulna, is a depression or pit into which the corner of the triangular fibrocartilage is inserted. When the radius is broken at the point described, the unexpended force alluded to above is all brought to bear on these two attachments connecting the hand with the ulna, directly through the ligament and indirectly through the fibrocartilage. The ulna does not articulate with the carpus, but finds a substitute for a bony socket in the fibrocartilage which originates from the side of the radius and covers the articulating surface like a hood. Both the ligament and cartilage usually give way, but sometimes the cartilage alone.

"When we inspect the anatomic arrangement, it is palpable that the fragment broken off from the radius could hardly be driven a half-inch above its normal position without a rupture of this singular ligament. It must almost inevitably give way in every fracture at this point. It has a broad insertion along the side of the end of the radius, and a narrow and weak one in the pit at the root of the styloid process. When the ligament is separated, as is almost surely done by pulling off a scale of bone or even the entire process, which is weaker than the fibrous structure of the ligament, the triangular fibrocartilage gives way at its weakest point—the insertion into the pit at the styloid—and thus the ulna becomes dislocated. But the force may be still more, and sufficient to change the position of the end of the ulna. The scale of bone drawn from the surface of the styloid process leaves the end of the stump, brought to a sharp edge in most cases, and thus fitted to penetrate the tissues with which it comes in contact at the lower end of the forearm; the fascia has fibers running across the back of the wrist, and termed the posterior annular ligament. This unexpended force is sufficient to cause the styloid process to penetrate it and complicate the case. A still greater force, and especially if the resistance is aided by fracture of the radius above that of the Colles fracture, or a luxation of the radius at the elbow, may be sufficient to push the head of the ulna through the skin and produce a compound dislocation. Wherever there is a joint there may be a luxation, and this at a point described has been known both of the simple and compound form, but as a complication in Colles' fracture has not been observed, as far as I have been able to learn."

SYMPTOMS.—It is our duty to study the symptoms carefully, because in many cases they are so slight as to cause us to ignore the presence of a fracture. The fact that the patient has fallen upon the palm of the extended hand should always cause us to suspect fracture of the lower end of the radius. Crepitation and immobilization of fragments, symptoms of so much importance in other fractures, are almost always absent here, on account of the strong tendency to infraction. Pain at the seat of fracture is always a prominent symptom. Increase by pressure at the seat of injury. This is the only symptom on which you will be sometimes forced to make a diagnosis, as the following case will illustrate: M. G. White, male, age 14 years. On September 10, 1904, he was riding a bicycle and collided with a delivery wagon, striking the lower end of the forearm forcibly against the iron tire of the vehicle. He complained immediately of intense pain about five-eighths of an inch above the lower articulating surface of the radius. He consulted a physician, who expressed the opinion that he only had a sprain, and put the arm on a padded anterior splint. I saw the patient three days after the accident; he was then comfortable with the dressing, but as soon as the splint was removed the pain returned, and at the seat of injury you could elicit pain by gentle pressure. Dr. Stafford saw the case with me. I not agreeing in the diagnosis, we looked at the arm through a fluoroscope, and could detect no sign of fracture. I acquiesced in his opinion and we put the anterior splint on again. He returned at the end of five days, saying that he had not suffered since he left. We removed all splints. One week afterwards he returned with a well-marked deformity at seat of fracture, pain and inability to use the hand. We reduced the fracture and put it up in Moore's dressing with a padded anterior and posterior splint. Now here was a case of fracture of radius without any symptoms except pain. The antero-posterior diameter of the radius will be increased in proportion to the infraction and displacement existing. If the displacement has been very marked, then the deformity so aptly styled "silver forked" by Velpeau becomes prominent.

TREATMENT.—In discussing the treatment of these fractures my principal object will be to impress upon you the importance of effecting thorough reduction of the fragments, and using your splints to maintain this reduction. I say this because I believe we have been too often led to use certain manufactured splints to some certain fracture, causing us to ignore the first principle in treatment. Scudder says, "No splint is manufactured that fits the wrist accurately. If the surgeon depends upon manufactured and molded splints, he is in great danger of neglecting the fracture. It is but proper for the surgeon to use simple splints and to hold the fracture reduced by personally-applied pads and straps."

In the majority of cases you will find the patient requires an anesthetic to effect complete reduction, and I would advise every physician to use it when in the least doubt. In making reduction you will find it very practical to grasp the upper and lower fragments with the thumb and forefinger of each hand. By making traction you will be able to free the fragments, and then by pressing upwards, downwards, and laterally, reduction will be accomplished. After you have made reduction, it is very prudent to lay the hand down naturally and see if it will remain reduced;

if the deformity recurs, it will be necessary to use pads to prevent it.

After we have obtained thorough reduction one of the important measures will be to use splints which will not interfere with the free movements of the fingers. Moore relies upon compresses, circular strips of adhesive plaster and mitella in obtaining coaptation of fragments, and undoubtedly in his hands this treatment has yielded good results.

Nicholas Senn says: "The laity as well as most of the profession would consider such treatment short of the indications presented by the injury. Long ago I grasped the principle laid down by Moore in the treatment of Colles' fracture; but I have always deemed it advisable to support by mechanical treatment that would immobilize the hand, and thus add to the more perfect immobilization of the lower fragment." It is my general practice to apply Moore dressing and then put two well-padded splints—one anterior and the other posterior. The anterior splint should extend from the elbow to the wrist, while the posterior splint goes to the base of the fingers. They are held in place by three circular strips of adhesive plaster; one at the seat of fracture, one at the upper end of the splints, and one in the middle. Over this put a circular bandage. After this, by pressing the splints together they should show some slack still. The arm should then be put into a sling midway between pronation and supination.

It is always proper to look at the hand at the end of twenty-four hours and see if the pressure is not so severe as to interfere with the circulation of the fingers, thereby causing necrosis. This dressing can remain on for ten days to two weeks, when it will be sufficient to use only the posterior splint. The arm should stay in this splint two weeks more; in the meanwhile massage should be practiced every three or four days. In cases which show a tendency to deformity, the pistol-shaped splint of Dupuytren has accomplished good results in the hands of many surgeons. I believe, if the deformity should be intractable, putting the hand in adduction will improve the treatment.

The Roentgen ray is making possible a more complete adjustment of the fragments—with the least amount of traumatism, and it becomes the duty of the surgeon to avail himself of the accurate knowledge they afford in all cases.

After the removal of our splint we must be sure that union is firm, because it will often happen that the soft unsupported callus will be molded into some permanent deformity.

PROGNOSIS.—The two questions which will be asked you oftener are: Will I get good use of my hand? Will I have a deformity? The younger the subject, the less crushing there is of the lower fragment, the more perfect will be the functional and esthetic results. Dr. Senn, in his excellent book on Practical Surgery, says: "In reference to the prognosis it may be said that the functional result depends more on the completeness of the reduction than on the mechanical treatment calculated to maintain retention. A slight dorsal displacement often remains as an evidence of the existence of a Colles fracture in the practice of the most competent and painstaking surgeons, in consequence of more or less crushing of the spongiosa in the lower fragment. If the sub-luxation of the ulna is not entirely corrected at the time the reduction is made, a permanent radial displacement of the hand is the inevitable result. Even if the fracture heals with marked deformity ultimate satisfactory restoration of function is the rule. Speedy and perfect restoration of function may be confidently expected in cases in which the nature of the injury is recognized and perfect reduction effected, and retention of the fragments in their normal position maintained until the fracture has healed by bony union. The functional result is enhanced by resorting to methods of immobilization that do not interfere with the free movements of the fingers from the moment the injury was sustained. The complicating injuries of the adjacent wrist-joint, tendon sheaths, and other important paraosteal structures must be taken into careful consideration in predicting the probable result of the injury. Premature use of the limb, as well as too prolonged restraint, is in the way of obtaining a speedy and satisfactory functional result."

DISCUSSION.

DR. E. D. MARTIN—Gentlemen: The doctor has pretty thoroughly covered this ground. I shall not attempt to discuss the anatomy of this subject.

The prognosis is largely governed by the extent of the injury and the time at which we get the case.

The diagnosis is not difficult if we get the cases almost immediately after the accident. If they reach us, however, after the swelling is rather extended, there is some difficulty. There is then danger of being mistaken, even in diagnosis of fracture. I recall the case of a young lady who fell on the skating rink. The diagnosis was fracture, but under the X-Ray we found that there was no fracture.

The question of reduction and fixation is one of great importance. I believe that the old teaching that we have to keep them up four to six weeks is a mistake.

After two weeks we are perfectly justified in removing the permanent bandage and putting on a lighter bandage, and allowing them to use the hand. I believe that a great deal of trouble comes from keeping the hands in bandages too long.

There is one point of great value, and that is to never fix the fingers. Fix the palm of the hand, and allow the fingers free movement. By doing this we overcome a great deal of that stiffening of the fingers which usually follows.

By attempting to hold it in position while applying the splint there is danger that the fracture will slip, and a deformity will be the result.

I have often seen fractures of the arm treated with splint, and no fixation of the elbow. Unless you fix the elbow so as to perfect the rotation of the arm, you do more harm than good.

If we have a simple fracture, without much laceration of the tissues, we can probably put it up better in plaster splints, though you must be very careful unless you are accustomed to applying plaster splints.

DR. E. DUNBAR NEWELL—Dr. Grémillion has covered the subject so thoroughly that there is very little to be added, further than to emphasize some points.

One point in the symptomatology. Wherever we have a localized pain from one inch to an inch and a half above the end of the radius, it is indicative of a fracture.

A point in the differential diagnosis between dislocation and fracture is as follows: The radius extends about a half inch lower than the ulna. When we have a dislocation the relative lengths are unchanged, but when we have a fracture the relative lengths are altered. As to the treatment, I think it is a matter of importance that the shaft of the radius should be in the position of supination, and the hand flexed and adducted. Put it in a straight posterior splint, well padded over the flexed hand, and if we once get the fracture reduced the splint will hold it fast. I do not think the splint ought to stay on over two weeks. If they are allowed to stay on longer there will be stiffness in the joints.

Dr. Thiberge—There is one point that I would like to lay a little more stress upon, and that is the use of the X-Ray.

In one case, he said, the X-Ray was used and the diagnosis was faulty. In this case, possibly an anterior-posterior view of the end had been made. I think that if a lateral view had been taken the dislocation would have been recognized.

I think that in all cases the X-Ray ought to be used.

Dr. Jacoby—I cannot agree with the doctor on the fixation of the elbow. I believe that there is not so much rotation of the elbow as we think. This is especially true of the Colles fracture.

In fractures of the lower extremity of the forearm, where we have a double splint with the arm extended, it is a long time before the man is able to use his arm, and I remove the splints as early as possible, applying adhesive plaster over the fractured part instead.

Dr. Grémillion (in closing)—As to the length of time that the splints should stay on, I believe that they should stay on ten days or two weeks, and after that they ought to be removed every three or four days, in order to massage the parts.

A Plea for the More General Use of Electro-Therapeutics.

By Amedee Granger, M. D., New Orleans.

My purpose in preparing this paper was with the hope of infusing some interest into this society in a much neglected and abused branch of therapeutics. I have found that the two most generally entertained views of electro-therapeutics by the members of our profession are: First, that it is of value but requires such an outfit and such an amount of special training that it is no longer a method for the general practitioner, but for the specialist. Second, that it is of very doubtful efficiency, that its action is mainly psychological, and, further, those who entertain this view discredit largely the very excellent results reported from its use.

Both views are incorrect. Because one has a knowledge of the primary branches of medicine, does it follow that without study or instruction he knows gynecology and surgery? Why should it be different with electro-therapeutics? Therefore, because one is an M. D. he should not hope without previous study or training to duplicate results with a static machine or wall plate which he has just purchased; and because he fails he certainly has no right to doubt that such results can and have been obtained.

Electro-Therapeutics is no more a specialty than gynecology, strictly speaking. Every physician does some gynecology, and with good results, only referring patients to a confrère who is better equipped, has superior facilities and a wider experience when the nature of the case demands it. So it is with electro-therapeutics. Any general practitioner who will devote to this subject the same amount of time and study which he does to gynecology or surgery, and who has a good static machine and wall plate, is perfectly competent to treat the large majority of cases requiring electrical treatment. The outlay is not great and when properly employed the results will not only be gratifying to himself, but to his patients also.

As the uselessness of drugs in a large class of chronic functional and organic diseases is becoming more generally realized, the value of the physiological therapeutic agents, electricity, hot air, hydrotherapy, etc., is becoming more generally recognized. Already we have in America three medical journals devoted to this important subject, and some of the best minds in this country and in Europe are investigating its possibilities. Electro-therapeutics, which is the most important of the physiological therapeutics, is being taught in the principal post-graduate schools and in some medical colleges. With one or another of the electric modalities we can accomplish all that the extra drug methods can do, and besides some results which it is impossible to obtain with them. It has the further advantage that it is the only really practical one for office practice.

It is true that we do not know the exact nature of electricity, but we do know and understand its laws in motion; the physiological action and therapeutic indications of the several currents, and to us as practitioners that is the most essential. With continued improvements in the manufacture of the apparatus, and greater uniformity in nomenclature and reports of observations, we are rapidly arriving at an accurate knowledge of the therapeutic indications of the different currents, and also the limitation of their field of usefulness. Certainly no other branch of medical science has more sound and rapid progress in the last fifteen years.

In the time allowed it is useless to even attempt to review the field of usefulness of this valuable therapeutic agent, and I will therefore merely discuss the treatment of three of the most common chronic diseases, which you meet almost daily in your practices. They usually do not respond to ordinary medical treatments, and yet have been successfully treated with electric currents by others and by myself.

CONSTIPATION.—Constipation is by far the most common disease for which we are called upon to prescribe, and usually those cases continue to their grave using first one pill, then another. Its effects are far-reaching, causing many constitutional and local disturbances, and in cases in which it exists as a complication, retarding the progress of the case, and not seldom preventing permanent cures. We will not discuss the etiology of constipation, for the fact remains that whether due to atony of the intestines, or to spasms of the intestinal fibers, or to some other causes, all our later cases were cured by galvano-faradization. This method is easier of application, less disagreeable to the patient. gives better results, and this in less time than a half dozen other electrical methods, including rectal applications which we have used in these cases. Its action is briefly explained by the following observations, viz.: It has been established: 1 That the passage of a continuous or galvanic current causes contraction of the intestines. 2. That the contraction is greatest at the positive pole. 3. That it lasts during the whole time of the application, disappearing shortly after the current ceases to pass. It was further observed that the induced or faradic current causes contractions of both the circular and longitudinal fibers of the intestines. 4. That these contractions are much more active when the current is derived from a long and fine wire coil. Later, Bordier and Clazet proved conclusively that, when using galvano faradization, if the faradic current is obtained from a coarse, short wire coil the stimulation of the unstriped muscular fiber is not as great as from the employment of the faradic current alone, provided the latter is derived from a long and fine wire coil.

The technique is very simple. The patient being recumbent on a couch or operating table, two large pads at least 7x11 in., thoroughly wet and soaped, are placed respectively over the abdomen and under the lumbar spine. The combined currents—*i. e.,* galvanic and the faradic from a long, fine wire—are made to traverse the whole intestinal mass. The positive pole of the combined currents is connected to the abdominal pad and the negative to the dorsal pad.

The intensity of the galvanic current employed by us ranged between 50 and 100 Ma.; 150 Ma. has been used and recommended. The duration of the application varied between 20 and 30 minutes. This is an important consideration, if rapid and permanent results are desired. Cures were effected in from four to six weeks. The treatments are made daily at first, and after normal daily movements of the bowels have been established, they are made three times a week, and later twice a week. Our experience with this method is yet too recent to be able to speak of the permanency of the cures, but Dr. Bordier of Lyons reports several cases kept under observation for periods of from six months to one year without recurrence of the trouble. Neither Dr. Bordier nor ourselves paid any attention to either the diet or the hygiene, but we believe that this was a mistake, and in the patients which we now have under treatment we are striving to correct existing errors in diet and hygiene, and we not only expect more rapid cures, but we believe that these will prove permanent if the patients continue to follow our instructions.

Dietetic and hygienic measures form, in our opinion, the most important part of the treatment of constipation by ordinary methods of treatment, and although alone, or even in combination with drugs, they often fail to cure these patients, we firmly believe that, if constipation is cured by galvano-faradization, those measures will keep him welll.

Here we wish to recall the fact that dietetic and hygienic measures are certainly not remedial agents, but with electro-therapeutics belong to the family of extra drug methods which I have mentioned above as physiological therapeutics.

NEURASTHENIA.—Another very common disease, in fact so common in our cities that it has been termed by our European confrères the American disease, is neurasthenia. This disease, which has been so admirably studied and described by the late Dr. George Beard, is best briefly described as a nervous bankruptcy. It presents so many-sided clinical pictures that it is not always easy to recognize it, and in its aggravated types when no recognizable pathological condition can be detected, and after it has resisted all medication, it is not rarely diagnosed as hypochondriasis or hysteria.

The neurasthenic patients can be divided into two large classes. In the first we find the cases of general neurasthenia with or without local manifestations. These usually occur in the weakest or most often used organs. In the second class belong those cases of local neurasthenia resulting from chronic local disease associated with general neurasthenia. The patients belonging to the first class get well much faster, and only require a general treatment, as the local manifestations take care of themselves when the general nervous tone has been restored. The treatment of the second class of cases is more tedious. The local pathological condition which caused the whole trouble must be cured or greatly ameliorated before a cure of the neurasthenia can be looked for.

In all cases, however, the general treatment is essential, as it is very doubtful if, even after removing the local disease, the patient will get cured, unless the general nervous tone has been improved. The treatment which has given us uniformly good results is static electricity. The local disease is also very often favorably influenced by static or high frequency currents. These currents in a general way increase metabolism and the body function, and restore the equilibrium to normal. The general circulation is improved and general stasis removed by the stronger cardiac action and the rise in arterial pressure which these currents cause. The increased metabolism and better circulation caused increased combustion and oxidization, with a resulting increase in the excretion of urea and CO_2. The digestion and sleep are improved usually from the beginning of the treatment.

Our results have not only been satisfactory, but permanent;

two grave cases discharged cured two years ago have remained so. A word of warning in the management of these cases. Dr. E. Bonnefoy, who has made a special study of the treatment of this disease by static electricity, recently published two very interesting observations. 1. That as indicated by the sphygmograph the arterial pressure is always below normal in these patients. 2. That often the first few treatments, unless given very cautiously and for only a few minutes, produce a sudden rise in the arterial pressure, which greatly disturbs these patients, often causing an aggravation of all the symptoms, especially the insomnia and cephalalgia. You will appreciate more fully the importance of these observations when we say that we can recollect at least two of our cases in which these untoward effects were produced. Both patients decided that electricity did not agree with them and would not return for treatment.

DYSMENORRHEA.—We will limit our discussion of the treatment of dysmenorrhea to that condition of painful menstruation so often seen in young girls where there exists no recognizable pelvic disease. Associated with it we commonly find a neurotic constitution, vaso-motor disturbances and habitual constipation. Numerous theories have been advanced to explain the etiology of painful menstruation. The best is that which regards it as a neuro-muscular phenomenon. This is better understood if we recollect that there are two theories as to the significance of pain. The first and most generally accepted is the economic or biologic theory—*i. e.,* the pain becomes the instrument through which danger signals are thrown out against perilous overstimulation in one way or another. The second and less popularly received theory is that pain is the expression of the quality of the activity of the various organs or parts of the organism. In other words, pain is experienced whenever the physiological reaction which determines a specific stimulus is less in amount than the energy of the stimulus. According to this last theory, which we have adopted, the attempt at the performance of an important function, such as menstruation, while either the nerve centers in the cord or the uterus itself are in an unprepared condition, results in pain. In brief, instead of the normal physiological reaction, there is a spasm of the uterine neuro-muscular apparatus, during which menstruation is temporarily impossible. This would not only explain the painful menstruation in the cases under discussion, but also in those cases in which there exists a pathological state of the uterus, or adnexa, or both.

The treatment is very simple, consisting of percutaneous abdomino-dorsal applications of the continuous current. Two large, well moistened pads are applied respectively over the lower abdomen and under the back, and the current is turned on very gradually without shocks. The dose is usually 25 Ma., but varies between 10 and 60 Ma. with the individual cases. The applications are made daily or three times a week, beginning, whenever possible, about one week before the expected flow. When this is established these are discontinued temporarily, to be resumed again during the intermenstrual epoch. It is rarely necessary, even in cases of long standing, and where pain was very severe, to continue this treatment more than two months. In exceptional cases, when this treatment fails, it becomes necessary to make vaginal or intra-uterine applications.

We have in mind the following interesting case, viz.: A young girl 17 years old, who had never menstruated, but since the age of 15 had, at irregular intervals, attacks of pain in the lower abdomen, and in the iliac fossæ, associated with epistaxis. We saw this patient a day or so after one of those attacks, and instituted electrical treatment at once. The applications—abdomino-dorsal—were made three times a week with a current strength of 30 Ma., the negative pole being connected to the abdominal pad. At the end of three weeks she saw for about a half a day. There was no epistaxis, and the pain was negligible. The same treatment was continued during the following intermenstrual epoch, with the result that menstruation was established, the flow this time lasting three days. No more treatments were made, and the patient was well six months later.

Report of a Case of Tetanus Following Wounds Inflicted by the Explosion of a Gigantic Fire Cracker.

By Dr. F. M. Thornhill, of Arcadia.

As bearing on the etiologic relation existing between wounds inflicted by fireworks and tetanus, I had thought that a report of the following case might be of interest to the society. On June

18, 1901, I was hastily called to see Garland L———, a little white boy, age 4 years. On arriving at the house I found the little fellow in a semi-conscious condition from shock and most frightfully mangled and mutilated. A careful examination revealed the presence of a number of large, lacerated wounds. The skin on the right hand had been literally stripped off on both the dorsal and palmar surfaces as far as two or three inches above the wrist, and was hanging in shreds, and the carpal and metacarpal bones, together with the phalanges, had sustained more or less injuries. On the abdomen, just above the pubic symphysis, was another large wound extending to near the lower border of the umbilicus in a vertical direction, and two or three inches transversely, tearing away the skin and muscular structures very nearly down to the peritoneal cavity. On the anterior and fleshy part of the right thigh were two other wounds of about the same dimensions as the one on the abdomen, and on the left thigh there was quite an extensive wound, but somewhat less than the ones last described. On the dorsal aspect of the left hand there was also a considerable wound, while on the face and other parts of the body there were a number of smaller ones. Previous occupants of the house had left a large fire cracker on the premises and the little fellow discovering it, concluded, as he afterward said, "to scare and have some fun" out of a young lady sister who was in another room, by exploding it. He accordingly placed the missile on a window sill and applied a match with the result above described. I found it necessary to amputate the hand which had been so badly mangled, which I did at about the junction of the lower and middle thirds of the forearm. The wounds were cleansed as best they could be, and antiseptic dressing applied. The little fellow reacted promptly and everything seemed to go well until the eighth day after the injury, when symptoms of tetanus began to show themselves, and within the next twenty-four hours the tetanus picture was fully developed. The first noticeable symptom was a little stiffness of the jaws and neck, accompanied with difficulty of swallowing. Gradually all the facial muscles became involved, the eyebrows lifted up, the angles of the mouth drawn out, producing the so-called sardonic grin. Later opisthotonos became prominent, the abdominal muscles hard and rigid and general tonic spasm rapidly supervened and death closed the scene, amid great agony, within forty-eight hours from the manifestation of the first symptom. After death the stump of the amputated hand was found to have healed perfectly. On account of the number and magnitude of the wounds, and the fact that some of the wadding had been deeply buried in some of them, I was led to fear tetanus, fortunately a fear expressed to the family at the time. The large number of cases of tetanus occurring in the United States immediately after each recurring Christmas holiday season, and the annual celebration of our national independence day, as the direct result of wounds inflicted by fireworks, make it a subject of national importance and one that should engage the attention of the medical profession from both a scientific and humane standpoint, and the aid of our statesmen and law-makers should be invoked in suppressing its deadly ravages, by proper legislation.

Society Proceedings.

Orleans Parish Medical Society.

President, DR. L. G. LEBEUF. *Secretary,* DR. ALLAN EUSTIS.
141 Elk Place, New Orleans.

In Charge of the Publication Committee, DR. ALLAN EUSTIS, Chairman,
DRS. JULES LAZARD and H. DUPUY.

MEETING OF SEPTEMBER 12, 1905.

DR. O. L. POTHIER read a paper on

The Pathology of Yellow Fever.

(*Abstract.*)

Remarks based on his work at autopsy. Extreme fatty degeneration of organs notable. An autopsy taken as example.

1st. *Appearance of Body.*—Yellow in extreme cases (sclera also). Post-mortem hypostasis marked also ecchymoses (face, neck, chest, scrotum and penis).

2d. *Opening of Body.*—Yellowish discoloration of subcutaneous tissues, particularly cartilaginous structures.

3d. *Lungs.*—Nothing special, except occasionally extremely marked hypostasis.

4th. *Heart.*—Appears fatty (dead-leaf color). Myocardium friable, yellow (boxwood). Ecchymotic spots at base and over large vessels.

5th. *Liver.*—Golden yellow (boxwood) color. On section shows lobules massed together, the whole surface being clean cut.

Above lesions are those found in marked cases of yellow fever.

Kidneys found fatty and congested. Spleen always normal, as far as any changes from the disease go. No congestion or parenchymatous increase of tissues. Sometimes found enlarged, but this probably is due to previous malaria.

Congestion of mesentery and walls of stomach. On opening latter it shows intense congestion, with ecchymotic spots, particularly at oesophageal end. Contents are of a grumous character. The same contents found in beginning of small intestine. Farther down tract no change noted.

Frequently these characteristic changes not noted at autopsy when cases die early in the disease. In these cases the autopsy shows the possibility of a death from the disease without any naked eye signs of it. This is explained by the virulence of the poison killing before the characteristic degeneration of organs could set in.

Similitude of yellow fever to cases of septicemia dwelt on. In latter, spleen is always affected, being muddy in color, and its pulp peeling off like thick mud when cut surface is scraped.

Microscopically the extreme fatty degeneration of cellular elements of parenchymatous tissue of organs is notable. In heart and liver this is particularly so (oily globules). Kidneys also show this in tubules.

Whole picture is fatty degeneration of all parenchymatous tissues of organs. Some authors say this is even so in the endothelial lining of blood vessels, but this is not proven.

On cutting the liver a yellow line is found at the periphery of the lobules, which shows the beginning of fatty degeneration. This would point to a positive diagnosis in a case which was suspicious.

There is no characteristic lesion of any special organ. The whole picture is one of fatty degeneration, congestion of the stomach, and ecchymoses, which, taken with the clinical history, gives the diagnosis.

Microscopical examination of the blood does not show much change in it. There is not much degeneration of the red blood corpuscles. The blood count shows, if anything, an increase, and also in the amount of hemoglobin. The latter is lower at the start, but soon rises. The count of the white blood corpuscles is lower than normal.

The urine, on examination, gives albumen, as a rule, on the fourth day; sometimes it is delayed as late as the seventh. Bile appears about the same time or possibly a little later. Casts appear about the third or fourth day. The majority of authors think the changes in the kidney and liver are not strictly speaking a degeneration, but rather a rapid infiltration by fat. They argue that, if it were a degeneration, subsequent changes and damage would result, which is not the rule.

DISCUSSION.

DR. OECHSNER would like to have Dr. Pothier explain the apparent paradox between no changes in the blood and the change in the blood in black vomit.

DR. POTHIER—The fact that there are changes in the blood is due to the changes in the endothelial lining of the blood vessels of the stomach. This causes hemorrhage into the stomach, and the blood is acted on by the gastric juices. Black vomit is not characteristic of yellow fever, as witness its occurrence in cancer.

DR. L. F. SOLOMON read a paper on

The Treatment of Yellow Fever.

I was very much disappointed at the last meeting of this society, and left with great sorrow, because of the fact that the younger members, who had come for the purpose of being instructed and gaining information in regard to the treatment of yellow fever, must have gone away with saddened hearts, feeling that they were all at sea, because of what was said to them. They were told, practically, that there is nothing to do.

I beg to differ with the gentlemen who spoke on that occasion, and want to say now, to the members, particularly to the younger members of the profession who are here tonight, that there is much that can and should be done. In thinking over the unsatisfactory results of the last Society meeting, in regard to this particular point, it occurred to me that I would give you a short lesson or plain talk upon the practical therapeutics of yellow fever.

In conversing with your president he suggested that I should put my remarks in writing. Perhaps it is best that I should do so, because of my many years of experience with the disease, an experience as large and as varied as that of any member of this Society, with probably one or two exceptions.

I perhaps should have published what I have now to say in regard to the treatment of yellow fever after the experience of 1897, 1898 and 1899, but I considered that after the last visitation of the pestilence, that that was not the proper time to publish my views, because of the fact that the disease was a thing of the past, and that anything that I might say or publish then would be read and laid aside and probably forgotten, before another visitation would come upon us, if ever it should. Without detaining you further, I shall endeavor to make plain to you, as briefly as possible, because my time is limited, not only the treatment of yellow fever, from a therapeutic standpoint, but how a case or various cases, that might come under your care, should be managed and piloted to health.

In simple cases of yellow fever, it is true, there is very little for you to do, but that little is important. In case of complications and with the varied aspects the disease very often suddenly assumes, one should be equipped with the necessary knowledge of how to meet these changes and meet them promptly.

As a result of my experience in the treatment of yellow fever, I am going to make a very bold assertion. I believe that no one stricken with the disease, unless with pre-existing disease of the heart, or nephritis, should die.

I am prepared to make a still bolder statement. You were told at the last meeting held in this room that there was no specific for yellow fever. I believe that there is, and I shall endeavor to demonstrate to you that it is a curable disease.

Referring to the suggestion made by Dr. Pothier in his remarks upon the etiology of yellow fever, in which he stated that he believed that the poison was somewhat akin to the malarial plasmodium, he struck the keynote of what I have always believed, and upon this belief is based the treatment which I am about to suggest to you.

Many years ago, in the early days of my practice, I found that potassium nitrate was almost as efficient, if not as sure, an antidote to the malarial poison as quinine; and long before the microbiological investigations which have since been made, demonstrated that yellow fever was not caused by a microbe, the peculiar hemmorrhagic tendency of the disease, resembling so closely the hemorrhagic form of malarial fever, led me to use potassium nitrate in the treatment of yellow fever. As a result, I am prepared to state and also confidently assert that a case, if seen within the first twenty-four hours and treated according to the method which I shall give you, is so converted into a simple pyrexia, with rapidly declining temperature, terminating at the end of the third day, and not followed by the secondary rise so often seen.

Of course, you will understand that the mere administration of the drug does not constitute the entire treatment of any disease, but having, in the first instance, administered what I considered an antidote to the poison, then it becomes our duty to so manage the case as to conduct our patient to the safe harbor of recovery.

With these preliminary remarks, I shall now proceed to tell you how to treat yellow fever. The first step necessary is the administration of a large saline purgative, preferably sodium sulphate. This will thoroughly cleanse the entire intestinal tract. It is not necessary to give calomel or any purgative, because the sodium sulphate, in addition to its flushing power, also acts as a cholagogue. You will often find that when your patient is seized with the attack there is undigested food in the stomach. If such should occur with a short time after eating, he will vomit and empty the stomach of food. If the seizure should come on three or four hours after a meal, and there is still some undigested food in the stomach, there will be nausea. In such cases it is well to give minute doses of calomel for the purpose of quieting the stomach, so that the sodium sulphate will not be rejected. For this purpose you will find the following combination the best adapted to the purpose. A powder consisting of 1-4 grain of calomel with one grain of ingluvin. This to be repeated every twenty minutes until four are taken, and then followed in half an hour with one-half or 1 ounce of sodium of sulphate dissolved in a glassful of water. You will find very frequently that the intense cephalalgia accompanying the onset of the attack will be relieved after the administration of the saline. If not relief can be obtained by the old-time hot footbath which, by the way, I never use except for the relief of said condition. One hour after the administration of the purgative and without necessarily waiting for its action, I begin the administration of the following prescription:

Potassi Nitratis	dram 1
Liq. Ammoniæ Acetatis	ounces 3½
Syr. Aurant. Flor.	ounce ½

The adult dose of this mixture is half ounce, repeated every two hours during the continuance of the fever. The liquor ammoniæ acetatis is administered in conjunction with the potassium salt for its action on the skin, as it causes free diaphoresis, thus favoring elimination. The potassium nitrate in addition to what I consider its specific effect as an anti-toxin, also plays a very important part by acting as a prophylactic diuretic.

You will find, as a rule, within a few hours after beginning the administration of the above mixture, that the temperature, no matter how high at the outset, will begin to decline and will decline progressively until the end of the third day, when convalescence will begin.

In addition to the remedies mentioned, there are several cardinal points in the management of a case of yellow fever, which you should bear in mind. The first is absolute rest in the recumbent posture, not allowing the patient even to rase his head for any purpose whatever. Second, absolute abstinence from food of any description, liquid or otherwise, until the complete subsidence of the fever. Third, careful attention to the thorough emptying and cleansing of the lower bowel by large enemata administered at least once daily, using for this purpose two (2) quarts of normal salt solution. Water and ice should be allowed ad libitum, preferably carbonated waters such as Apollinaris, Carbonated Lithia Water or Seltzer water. If your patient is averse to the carbonated water, you may use plain Vichy.

After the fever has subsided you will very often find that the temperature becomes sub-normal. The patient is now in what is called the algid stage. Very often the extremities will be cold, somtimes the entire body is cold and clammy to the touch. For this condition there is nothing better to restore your patient to a normal condition than a small glass of ale, administered every two hours in conjunction with nux vomica and caffeine. I usually administer one-eighth grain of extract of nux vomica with one or two grains of caffeine citrate every two or three hours, as the case may require.

In beginning to feed your patient, which you may do on the fourth or fifth day of the disease, great care is necessary. For the first day you may give two ounces of weak chicken broth, to be repeated at intervals according to your judgment, and nothing else. I find the next best step in the feeding of the patient is the administration of buttermilk. Buttermilk is easily retained and digested, besides being grateful to the patient. From this you may go to sweet milk, beef or chicken soup thickened with rice or barley, and after a few days gradually return to the normal diet.

I have outlined above the treatment of a simple, uncomplicated case of yellow fever, but you will often be confronted with cases that will tax your ability and ingenuity to the utmost.

We will begin with the most ordinary complication, the one most often met with, that is nausea. This can generally be relieved with milk of magnesia. This failing, there may be added to it one or two minims of creosote.

You will occasionally find that in spite of your treatment the temperature continues high. In your efforts to reduce high temperature beware of the use of so-called anti-pyretics; such drugs as phenacetin and its congeners are positively vicious in their effects. The disease itself is sufficiently depressing without adding to the depression. I firmly believe that many a life has been lost in yellow fever by the administration of these preparations. You will find that water externally, either by sponging or the application of the wet towel, will almost invariably reduce the temperature. Never use ice water. My method is to use tepid water always. Frequent sponging will generally reduce the temperature. If not, the application of the wet towel will accomplish the desired result, particularly if you carry out the following plan, which I have often adopted. The patient is covered from chin to feet with a large bath towel saturated with tepid water, and then the nurse or attendant is made to fan the patient, thus creating a current of air and causing rapid evaporation and equally rapid reduction of temperature. I have, many times, in this manner brought a temperature of 104½ or 105 below 103 in half an hour.

The next step to be considered is black vomit. I pause here to state that in 1878, at the outbreak of yellow fever in New Orleans, I gave the result of my experience (in a discussion at the New Orleans Medical and Surgical Association), with ergot in controlling black vomit. The suggestions then thrown out, based upon past experience, were adopted by a number of physicians during that epidemic, and Dr. S. S. Herrick published the result of his experience in the use of ergot in yellow fever. I have frequently and almost invariably controlled black vomit with hypodermics of ergot, administered by the stomach, of creosote, either with simple chalk mixture or milk of magnesia, and the application of the ice bag to the epigastrium.

Now we come to the most dangerous condition that will confront you in yellow fever, and one of the most difficult to overcome, that is the enuresis. As a rule, under the treatment above suggested, this condition is very rare, owing, as stated in the beginning, to the prophylactic diuretic effect of the potassium nitrate. Should, however, the urine become scanty or altogether cease, you will find your remedy in ergot. Right here, I beg to differ with my friend, Dr. Matas, who stated in his remarks at the last meeting that ergot was useless in yellow fever, because you could not expect it to have a contractile effect upon arteries that were in a state of degeneration, and also that no remedy was of avail upon a kidney which was in a state of previous fatty degeneration. Now, I am inclined to believe that the fatty degeneration of the liver and kidneys and other organs, which we find post-mortem, are conditions which come on immediately ante-mortem, that these great changes do not occur until the patient is moribund, and then take place very rapidly. Of course, this is something that cannot be demonstrated, as we have no way of investigating the pathological condition of the living patient. I am inclined to this belief because of the fact that, even in the most violent cases of yellow fever that recover, the functions of these organs are so rapidly resumed that it is hardly possible that they have undergone a condition of previous fatty degeneration. Owing to the interference of the partial circulation caused by the enlarged and engorged liver, there is an entire congestion of the abdominal organs, including the kidneys. I believe that ergot, by its contractile power upon the arterioles, relieves that congested condition, and the kidneys resume their normal function. In addition to the ergot, also administer Lithia water very freely.

Now, gentlemen, while claiming, as I did in the beginning, that the potassium nitrate was an antidote for the yellow fever poison, I do not claim that it will cure or relieve all cases, that is something beyond human possibility, but from my experience with over two hundred and thirty cases, without a single death, I am led to believe that in the large majority of cases, by pursuing the treatment above set forth, you will pilot your patient through the shoals and rocks to the harbor of restored health.

I submit the foregoing remarks to you with the hope that you will cut loose from the dicta and dogmas of those who have little faith in the efficacy of drugs even when properly and intelligently applied, and that some of you at least will be sufficiently independent in thought to give a trial to the method of treatment of yellow fever herein set forth.

"Why even of yourselves, judge ye not what is right?" The question is appropriate now as it was nineteen centuries ago. Even in the light of what practical experience has demonstrated, there is a tendency, more prevalent among the younger members of the profession, to timidity in independent thought, an instinctive impulse to cling to theoretical ex cathedra teachings, simply because they are laid down in the text books, written very often by men who have probably never seen a case of yellow fever, or because they emanate from the professorial chair; a tendency, when a new truth is enunciated, to crawl under the wing of higher authority to protect themselves. Medical emancipation and success in its practice cannot come to you in this way. I only ask that you will give some heed to one who has had a large experience in the practical treatment of yellow fever. Weigh its claims in the balance of your own judgment, settle them in the court of your own conscience, and if after all I shall have contributed the least iota to your knowledge wherein you can be instrumental in saving life, I shall be amply repaid.

And now, gentlemen, I leave you with the Scriptural injunction, "According to your faith be it unto you."

DISCUSSION.

DR. BATCHELOR was under the impression that there was no specific for yellow fever. There is greater opportunity for the use of good judgment and nursing than for drugs. He cannot agree that there should be no mortality in yellow fever. His specific, if he could believe in any, is water, water, always water. Has had no experience with potassium nitrate, so he cannot pass upon it. Agrees with the doctor on the necessity of freeing the intestinal canal by the use of a saline in order to further elimination in every way. Watch the kidneys, stomach, skin. Increase the function of the kidneys by giving alkaline water freely by mouth. Supplement this by hot saline enemas. Does not believe in infusion as his experience has convinced him that this frequently results in black vomit.

As to feeding he is guided largely by the stomach of the individual patient. Sustains his patient by the use of liquid food in such a quantity as he can take without upsetting his stomach. For the control of fever he uses cold water. Has used cold pack or ice water enema, the latter giving a reflex action on the kidney at the same time. The use of stimulants after the stage of calm (after secondary fever) is left to the judgment of the physician. He has found caffein splendid, as it acts on both heart and kidneys. Where the heart action is increased he uses digitalis with good results. Nausea is to be treated by counter irritation, such as mustard plasters to the pit of the stomach. In case of black vomit, absolutely nothing to be given. Ergot theoretically should do good in this as well as in enuresis. He believes fatty degeneration takes place just before death.

Summing up his treatment the main points are good nursing, quiet, repose and free ventilation.

DR. POTHIER wishes to correct the impression that he said there was no fatty degeneration of organs till immediately before death. What he said was that some authors thought that the condition was one of rapid infiltration and not degeneration.

Dr. Dabney does not think that potassium nitrate is any better than arsenization. All the cases he saw treated by the use of potassium nitrate in conjunction with calomel as a purge died, therefore he would say don't give the potassium unless a saline is used in place of calomel. The use of frequent water enemas, two quarts to a gallon, gives good stimulating effect. If the patient is in febrile stage use cold water; if in calm stage, use warm. Any food in the first three or four days is injurious and the risk in giving it is very great. His rule is to give no food for the first three to five days, and when begun it should be liquid, such as beef tea. Give a plentiful supply of water, using it for drinking, sponging and enemas.

Dr. Walet does not think there is any specific treatment, and in the absence of such he treats every case on its own merits. Wishes to emphasize the influence you can wield on a patient by psychic suggestion.

Dr. Watson—Research work has shown that a limitation of the water supply in acute nephritis gives very much better results from the kidneys. Would, therefore, think a limited supply in treatment in yellow fever would theoretically give better working of the kidneys. Would like to have this point more fully discussed.

Dr. Storck would like Dr. Salomon to bring out the value of dry cupping in the treatment of black vomit. Would also like to know if the doctor has had any experience with adrenalin.

Dr. Nelken thinks there is a relative immunity against yellow fever among natives of New Orleans. In '97 and '98 in the male wards in the Charity Hospital there was a death rate of 33 per cent. with but one death occurring in the native born man. He also noted not a single death in cases admitted to the hospital on the first and second day of the disease. One death occurred in a case admitted on the third day. All other deaths occurred in cases admitted after the third day. He believes ergot should never be given for internal hemorrhage, and thinks adrenalin might be valuable for its action on the stomach in a case of black vomit.

Dr. LeBeuf would like to remind the members of the remarks of the late Dr. Bickham, who impressed on the society, in a discussion of yellow fever, that there were three essential points: absolute rest in bed, water all the time, and no drugs or feeding.

Dr. McGehee wishes to emphasize the point of light mortality in yellow fever. If treated on the lines previously suggested it should never be higher than 5 to 8 per cent. Prompt and early treatment is necessary. Always remember that the skin is a complementary organ to the kidneys, and hence valuable when these are diseased. If a case develops nausea let it absolutely alone. Keep the stomach entirely free of food of any character. Use the alimentary canal, which is not much affected, as shown by Dr. Pothier. Use this even for getting water into the body.

Dr. Guthrie has found that the blood pressure in yellow fever is uniformly low (100 millimeters by the Riva--Rocci instrument). Thinks, therefore, that the slight increase in blood pressure from a free use of water is not sufficient to contra-indicate its use. Finds a diminished coagulability of the blood. Has been using brewer's yeast to see if it has any effect on the decreased leucocytosis.

Dr. Bel would like to know what to do in case the patient refuses to submit to a cold pack or sponging to reduce temperature. (Dr. Batchelor suggests ice water enema.)

Dr. Walet would like to know how to treat mild cases of yellow fever which might possibly be malaria.

Dr. Pothier—Have the blood examination made in order to determine the diagnosis. It is rare to see malaria and yellow fever in the same patient.

Dr. Matas wishes to bring Dr. Nelken's point in reference to immunity in native-born people before the society. This old belief has been exploded by the researches of the Yellow Fever Commission in 1897. There is no greater fallacy, as has been shown by Guiteras and others in the study of infant mortality in Cuba. The accepted belief in the Antilles is that natives born there are not immune on account of that fact, but rather because of having had a mild and probably unrecognized case of yellow fever in infancy.

Dr. Salomon (in closing)—Has never used dry cupping in the treatment of black vomit, but has used counter irritation with fair success. In 1878 he treated 366 cases of yellow fever, with a total of 10 deaths, before he began using potassium nitrate. Since then he has not lost a single case, and believes it is due to nitrate.

RELATION OF CASES.

DR. KNOLLE would like to suggest that if we are to succeed in stamping yellow fever in New Orleans, one point to be attended to is a warning to druggists to stop their habit of counter prescribing till cold weather. He cited a case in point of a druggist treating a case in his neighborhood for suppression of urine, which case was unquestionably one of yellow fever.

DR. CHAVIGNY wishes to state a case in which he feels great harm was done by repeated inspections by experts. He saw the case last night and reported it to the proper authorities, who sent four or five experts to examine and confirm his diagnosis. The result this a. m. was that the family was scared out of their wits and the condition of the patient was very much worse. Would like to enter a protest against such doings.

DR. LEBEUF would suggest that Dr. Chavigny take the matter up with Dr. White, as he knows that Dr. White intends to put a stop to such doings. Would urge forbearance for the next two or three days, by which time the matter will be settled.

DR. BROWN moved and duly seconded that the society communicate with Dr. White, stating that the inspectors are annoying the patients of the individual practitioners, and that the society requests that he adopt such measures as will correct this evil. Carried.

Communication.

AIBONITO, P. R., September 18, 1905.

To the Editors of the New Orleans Medical and Surgical Journal:

It has come to our notice that the report of this Commission, published December 1, 1904, is being used by the manufacturers of Gude's Pepto-mangan to advertise their preparation of iron. As this advertisement puts us in a very unenviable and erroneous light before the medical profession generally, will you be kind enough to publish the following statement:

The advertisement in question purports to be a review of this report, and, having attracted attention, proceeds by erroneous deductions and half-quotations in such manner that one might believe that the Commission endorsed their preparation of iron as the best hematic in the treatment of the anemia of uncinariasis.

As a matter of fact, the report (page 119) clearly states that we found the carbonate of iron to give the best results. Our report, on account of the limited edition, has never reached the majority of our professional brethren, and for this reason we quote the portion referred to:

"It will be noticed that slight cases readily recover without iron, and here the difference in the tables is more marked, while there is less difference among the marked cases in proportion to their number. In other words, the more resistant cases of all grades received iron, but even then did not generally recover as rapidly as those less rebellious without, for while ferruginous preparations seem to act readily in some instances, still, in the majority, its effect was not marked. The rapidity of cure is due, apparently, more to the personal equation of the patient and the rapidity with which the parasites are expelled, than to the amount of reconstructive treatment. Thus it is quite difficult to accurately judge the comparative value of different iron preparations, yet it was noted, even by some patients, that Blaud's pills gave more rapid results."

We do not believe that a perusal of the histories of the eighteen cases which the advertisement quotes demonstrates the superiority of Pepto-mangan (Gude), as these patients recovered more slowly than others of the same type who took Blaud's pills or Vallet's mass. In fact, on account of this slow recovery the carbonate of iron was substituted for Petro-mangan in five of the eighteen cases (Cases 8, 9, 10, 13 and 15). We ceased to use Pepto-mangan and gave none to the later cases.

To support our statement, we invite attention to the following figures, taken from those given in the very report which M. J. Breitenbach Co. cite as proving the superiority of their preparation:

There are sixty-one cases reported in full with complete blood records and clinical histories. In eighteen of them Pepto-mangan was used save toward the termination of five of them, when Blaud's pills were substituted. In eleven cases Vallet's mass was used, supplemented by Blaud's pills. In twenty-nine cases Blaud's pills were used exclusively. Three cases have no bearing on the subject.

* * * * * * * * * * * * * * *

To bring out the difference between these drugs more vividly, eighteen pair of cases of like type have been tabulated, whose initial hemoglobins absolutely or nearly correspond. One of each pair was treated by Blaud's pills, the other by Pepto-mangan. The demonstration is all the more potent in that both drugs were used in their true role as blood regenerators, in conjunction with thymol administered to both alike.

* * * * * * * * * * * * * * *

Of eighteen pair of almost identical cases, the initial average of hemoglobin percentage in the cases treated by Blaud's pills was 21.9; in those treated by Pepto-mangan (Gude), 20.7; the average number of days under treatment was 48.7 of the cases treated by Blaud's pills; in those treated by Pepto-mangan (Gude), 80.7; the average gain of hemoglobin under Blaud's pills was 68.1 per cent.; under Pepto-mangan (Gude), 62.3 per cent.

We tried to use a variety of iron preparations and were offered the pepto-manganates made by this company. We had no idea that this preparation differed essentially from any other pepto-manganate of iron, and it certainly may not, but had we considered the pepto-manganates of superior value as blood regenerators, we would have said so. As it is, we have said the contrary, and wrote this company to that effect at the time we became convinced of it.

This Commission does not wish to be understood to consider the use of reconstructive treatment as a necessity in the anemia of uncinariasis. Such an idea is all the more absurd in view of the fact that in the 12,000 cases treated under its direction since June 1, 1905, comparatively little reconstructive treatment has been used, many cases receiving none at all. As our experience with this disease widens, our opinion is strengthened that anthelmintic treatment is not only curative, but promptly so in the vast majority of cases, iron or no iron.

Thanking you in advance for the use of your columns, we are

Very truly yours,
BAILEY K. ASHFORD,
W. W. KING,
PEDRO GUTIERREZ YGARAVIDEZ,
Members of the Commission.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Victory.

The battle is won. As we write there have been no deaths in New Orleans from yellow fever in six days. During that same period in 1878 there were 195, and even in 1897, the year the fever commenced very late and was considered so mild, there were 31 deaths from that cause during the corresponding time in this city.

The victory consists in the complete control of the fever before the advent of frost and the low mortality resulting from the disease.

Success is due to the application of modern and scientific methods of sanitation, chiefly the destruction of mosquitoes, the elimination of their breeding places, and, meanwhile, the protection of the sick from the bites of those insects by means of screens. These measures were inaugurated by the city health authorities, assisted by an advisory committee of the Orleans Parish Medical Society and the citizens' ward organizations. They were continued on a larger scale and with better system by the Public Health and Marine Hospital Service force, commanded by Dr. J. H. White, still with the co-operation of the Advisory Committee and the Citizens' Organization. The necessary expense was met by securing some state funds through the Governor, some city funds through the Mayor, and the remainder through subscriptions from public-spirited corporations and citizens.

A satisfactory termination was not reached as early as the most optimistic expected and for several reasons. The disease had had a good start before it became known to the authorities; early cases, when mild, as they are apt to be especially in children and colored people, escape recognition by the inexperienced; the first deaths are likely to be called typhoid or some other fever, and do not attract notice, as they are few. The indifference of some people, no matter how criminal we may deem it, led them not to report cases if they did not, in their opinion, need medical assistance. The ignorance of many, causing a failure to realize the importance of fumigation, but an exaggeration of its inconveniences, resulted in some more or less successful attempts at concealment of cases.

Now, however, that the battle is won we must immediately go on with the fight for future exemption from yellow fever and other epidemic diseases. We can derive valuable lessons from items of failure as well as success in the present campaign, and we must make them serve us in the time to come. We cannot wait for new laws, no matter how much we may think they are needed, but must do the best we can and promptly with the laws we have. By the time the legislature can make new enactments, and they can be put in force, the fight for next season will have been practically won or lost. With communities, as with individuals, prevention is better than cure, and now is the hour to spend time, energy and money; we must not wait until disease has entered or gained the slightest foothold; we must keep it out and leave no spot on which it can get its grip.

We are throwing no bouquets. The different elements of our population have mostly done well and those who came to help have been kind to us, but we all at best have done only our duty and protected our interests. We can show what is in us by remembering and teaching the lesson of perseverance.

Exchange of Serums.

In an "editorial comment" an esteemed weekly journal criticises the policy in vogue with American manufacturers of exchanging unused serum, in packages that have passed the time limit of efficiency, for a fresh supply. The objections urged are that it works a hardship to the financial interests of the biologic establishments and affects the physician and the patient by increasing the first cost of the products.

We view the matter quite differently. The manufacturers run less risk of loss than they would by the discredit into which antitoxins might otherwise fall through the temptation of using them after they have become outdated. This seems to be the light in which the makers of antitoxins have viewed it, and we can trust their business sagacity to make them look at it in the right way.

What interests the physician above all is the possession at hand at all times of absolutely reliable preventive and curative serums, and nothing is more conducive to that satisfactory state than the liberal practice of the serotherapeutic institutions of America. The slight increase in cost to the patient is nothing compared to the advantages to be derived from the constant and immediate availability of efficient remedies. Our contemporary thinks the custom of exchanging can be abolished "when biologic products find their way to the physician who judiciously anticipates his wants," but we fail to see how said physician can tell when he will suddenly need diphtheria antitoxin, for instance. So much depends upon its immediate use and its prompt action that we favor the continuance of the policy which has worked to the satisfaction of the patient and the physician without objection, as far as we know, on the part of the manufacturer and the dealer.

New Chemical Remedies.

The Swiss Association of Pharmacists has recently passed, at its general meeting, what seems to us a timely and beneficial resolution. It recommends that each manufacturer be compelled to publish on the label of each pharmaceutic product the following points: First, its chemical name, as well as its commercial denomination; second, its reactions (of identity), its melting or boiling point, and its solubility in ordinary solvents; third, its dosage. There are already so many comparatively new chemical remedies and they are being added to so frequently and constantly that pharmacists cannot be posted as to their physical characteristics and their properties, hence they cannot, without the information above mentioned, exercise the proper control as to their purity or their safe administration.

The President's Visit.

Not the least valuable lesson Roosevelt will have taught the American people is that of facing disease. There happens not to have been any danger in coming to New Orleans when the President did, but he was willing to come whether or not, if we wanted him. We are not afraid to fight, but as a people we are cowards about disease, and it is to be hoped the lesson will be taken to heart.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In Charge of Dr. P. Michinard, Assisted by Dr. C. J. Miller, New Orleans

Diagnosis and Treatment of Cancer of the Uterus.—One of the most noteworthy contributions that have ever been made to this subject was the paper read by Prof. Wertheim, of Vienna, before the British Medical Association (*British Med. Journal*) at its last meeting. For the past ten years there has been a constant effort to extend the field of radical operation, and it is only of late that the ultimate results are accessible in order that the proper comparisons may be made. Prof. Wertheim has been the foremost champion of the radical operation, and now presents his results in 270 cases operated by the abdominal route (with a few exceptions) in such a way as, by opening the ureters and separating the bladder and rectum, to have removed the cancerous mass together with a great deal of the cellular tissue and lymphatic glands. One of the greatest lessons to be learned from Prof. Wertheim's paper is the possibility of removing cancer, which has extended beyond the uterus, with a small mortality and a reasonable prospect of freedom from recurrence.

The mortality in the early work was from 15 to 18 per cent., but in his last 30 cases he has lost only two. This, he attributes, among other things, to the shortening of the duration of the operation, which at first was from 2 to 2½ hours; now, for easier cases, only one hour, in difficult cases one hour and a quarter. He was especially prompted to persevere with this work in order to give some hope to the large number of women who came for relief after the parametrium and vaginal vault were involved. Where only 10 to 15 per cent. were formerly subjected to hysterectomy, the proportion has now risen to 50 per cent., and will probably rise higher in the future.

Further extraordinary encouragement to persevere in his work resulted from the histological examination of the lymphatic glands and parametrium. Here, at last, the opportunity offered to receive enlightenment about the condition of the neighboring tissues in the different stages of uteric cancer. These researches became the groundwork of the operative technic. In 28 per cent. of the cases the regional lymphatic glands were affected with cancer. In a further 30 per cent. the glands were enlarged, more or less, but showed no cancer. The most important conclusion resulting from these investigations is that in only 40 per cent. of the cases can the usual vaginal extirpation be considered a radical operation.

Credit is given Emile Ries, of Chicago, for having first carried out systematic extirpation of the lymphatic glands. Prof. Wertheim, however, states that extirpation of the lymphatic glands is by no means the exclusive, nor even the principal object of his proceedings. On the contrary, he has from the beginning attached more importance to the thorough removal of the cellular tissue network round the uterus.

Now, as to the most important part—the results. After two years he had the certainty that, in spite of the several objections and their own critical examination, the after results were superior to those which had been achieved by the usual methods. Of the occurrence in scar and stump, otherwise so frequent, they saw nothing. Nearly all the relapses were in the lymphatic glands. Of cases operated on by his method, 60 to 70 per cent. remained free from recurrence after four to five years observation, a result hitherto attained by no one else; and if one estimates the number of these cases according to the proposal of Winter—not from the number of those operated on, but from the number of patients seeking relief—an achievement of 20 to 30 per cent. results.

Prof. Wertheim does not insist upon this radical procedure in cancer of the body of the uterus. Vaginal hysterectomy he deems sufficient for this class of cases.

From the discussion that followed it must be concluded that the English attitude towards the more radical procedures practically coincides with that of American surgeons.

The general tendency is to do only palliative surgery after the disease has invaded the parametrium or vaginal vault. The discussion in print reads very much like that of the American Gynecological Society at its last meeting. In England and America the radical operation has very few champions. Ries, in a recent editorial, calls attention to the astounding contrast between the opinions promulgated at the American Gynecological Society and at the German Gynecological Society. In German clinics the radical operation is being generally used and with the most hopeful results. It is also interesting to note that John G. Clark, in his annual review of Gynecology for Progressive Medicine, expresses himself as disappointed with the radical operation. He was one of the pioneers in this country in urging the extensive operation as practised by Wertheim, Ries and others.

Department of Therapeutics.

In Charge of Dr. J. A. Storck, New Orleans.

The Treatment of Acute and Chronic Gastroenteritis by a Diet of Buttermilk.—Elie Decherf, who is the physician to a home for infants at Jourcoing, in the north of France, gives his experiences with buttermilk during the epidemic of gastroenteritis in the summer of 1904. He tells of his failure with the water idea, and compares his results with those in former epidemics to the great praise of buttermilk.

Any fresh, clean, buttermilk may be used. A tablespoonful of wheat flour is stirred into a quart of the fresh buttermilk and then boiled slowly in an enameled or porcelain vessel, with constant stirring. After boiling for several minutes, a dessertspoonful of cane sugar is added. On standing two layers form, the lower being yellowish, and made up of clotted casein, the upper being clear whey. In feeding, care should be taken that the nipple holes are sufficiently large for the small curds to pass. The food is given in the same quantity and at the same intervals as any bottle food. At first, however, it is best to give very small quantities, frequently repeated.

The author concludes his interesting paper as follows:

(1.) Buttermilk is usually well borne by infants who take it better than sweetened boiled water, notwithstanding that vomiting at times occurs.

(2.) In cases that have not yielded to other régimes and medicines, buttermilk alone produced radical improvement.

(3.) Buttermilk is both a specific remedy and an assimilable food for these forms of diarrhea.

(4.) It should be used in all forms of gastroenteritis, and even in cholera infantum.

(5.) Buttermilk gives splendid results in rachitis.

(6.) Such a simple, efficient and universally available mode of treatment deserves a wider trial.—*Arch. de Méd. des Enfants.—Archives of Pediatrics.*

AMYL NITRITE IN HAEMOPTYSIS.—M. J. Rouget reports, in *Bulletins et Mémoires de la Soc. Méd.,* good results obtained by adopting Francis Hare's suggestion for the use of amyl nitrite inhalations in haemoptysis. The first case, in which he tried it, was one of a severe and obstinate character, which had resisted all the usual methods of treatment; rest, cold, morphia, ergotin, dry-cupping, icebag, etc. The first inhalation (10 drops) greatly diminished the bleeding, and the second dose stopped it completely. After this the patient kept the remedy at hand, and was able to avert fresh attacks, which attacks he could always predict from the arrival of a certain taste in the mouth. Nine other cases showed equally good results.

The effect is due to the toxicological properties of the drug, which lowers the blood-pressure and produces vaso-motor dilatation in the peripheral vessels. Filehue has proved that the capillaries in the lung are exempt from the latter effect.—*The Practitioner.*

MEDICAL TREATMENT OF SEROUS EFFUSIONS.—Dr. Thomas L. Soley, of Philadelphia, in discussing this subject, called attention to the importance of the study of osmatic disturbances, and to the opinion of Loeb and others that this is of greater importance than the mechanical factors of blood pressure. He pointed out the significance of the study of sodium chloride excretion and extension to the relation of the edemas as having a direct bearing on the dietetic treatment. He laid stress upon the value of sialogogues in selected cases, and the dangers of diaphoresis in skin edemas; this process removes the watery portion of the edema, leaving the solid material in a more concentrated form and with consequent more toxic properties. The limitations and applicability of diuretics was dismissed, especially of calomel, caffeine, theobromine and digitalis.—*American Therapeutic Society.*

THE PROPER SPHERE OF BROMIDES IN EPILEPTICS.—This paper by Dr. Frederick Peterson, of New York, was read by Dr.

E. D. Fisher. Dr. Peterson announced that he is convinced that more epileptics are injured than are cured by bromides. He depicted some of the symptoms which, he said, are produced by this drug; he informed the society that the bromides produce some of the forms of insanity, especially melancholia. If it must be used, small doses should be combined with antipyrin or some other similar drug. He is firmly convinced that outdoor exercise and a regulated diet are of great value, and maintains that ten per cent. of the cases sent to a farm or colony are cured.

In opening the discussion, Dr. Fisher said that he was not such an enthusiast in regard to the colony treatment, as he has seen epileptics go to those places and return without the slightest benefit. Although much attention should be paid to hygiene, yet he does not believe that the bromide treatment can be abolished, and he knows of no drug which can take its place. He has seen it used by a patient for twenty years without the slightest deleterious effect. He strongly inclines to the view that there is a pathological lesion in the brain in epilepsy, because of the identity of the aura and the cause in each recurring attack.

Dr. Cohen, of Philadelphia, stated that much of the depression which follows the use of potassium bromide is due to the potassium. Dr. O. T. Osborne, of Yale University, maintained that a better knowledge of the thyroid and of the parathyroid might throw some light upon the condition of epilepsy; probably in this disease a symptom only is being treated. He does not believe large doses of the bromides are necessary, and sodium chloride should be eliminated from the diet. Dr. A. J. Hall, of Washington, D. C., favored the use of bromides. Dr. R. Reyburn believes the nitrogenous diet should be cut down as low as possible in epilepsy.—*American Therapeutic Society.*

Department of Ear, Nose and Throat.

In Charge of A. W. Roaldes, M. D., and Gordon King, M. D., New Orleans.

Aspiration in Ear, Nose and Throat Diseases.—Sondermann is the inventor of apparatus designed for the treatment of suppurative conditions in the middle ear and the nose, which the author claims affords a more effective means of cleansing these organs of pus than those ordinarily employed. It consists of a hollow mask to fit tightly over the ear or nose, with a tube and rubber bulb attached, by which suction is made.

In acute and chronic suppurations of the ear the pus can be evacuated in this manner more thoroughly and with less pain than by the use of the Politzer bag or catheter, or by the Valsalva method, and no damage is done to the parts by too strong a force of suction.

It is recommended in accessory sinus disease also, but the writer thinks its usefulness very limited in that class of cases, for the reason that these are closed cavities with the exception of their nasal outlets and cannot, therefore, be completely evacuated by suction.—*Lancet,* August 12th, 1905.

Collodion Dressing for Intranasal Operation Wounds.—The question of post-operative dressing for intra-nasal wounds is one of vital importance to the rhinologist, and much has been done in recent years to obviate the necessity of packing the nose with gauze and at the same time to prevent post-operative infection and hemorrhage. By the judicious use of cocaine and adrenaline intra-nasal operations are made practically painless and bloodless, but the greatest annoyance, and sometimes danger, results from delayed hemorrhage unless proper precautions are taken to prevent it.

The usual custom, and one very generally in vogue at the present time, is to pack the nasal cavity tightly with aseptic gauze or cauterize the wound surface with the galvano-cautery. There are several disadvantages to this, however, chief among which are the discomfort to the patient and interference with the rapid healing of the wound.

Pischel, of San Francisco, relates his experience with collodion as a dressing in such cases, and this he finds overcomes these difficulties and at the same time serves to protect the wound and prevent post-operative bleeding. The author claims for his method some advantages over that employed by others who have advocated collodion, and in a series of 243 cases it proved entirely effective in 233.

The technic consists in first stopping all hemorrhage with adrenaline, painting the wound surface with compound tincture of benzoin, applying a thin piece of sterile gauze, and painting the whole with collodion. The collodion is then dried by means of compressed air blown into the nose and forms a protective hemostatic coating over the wound. There is no necessity for cauterizing or packing, and the dressing can be removed in from four to six days without fear of bleeding.—*Journal A. M. A.*, October 7th, 1905.

RELATION OF DIGESTIVE DISEASES TO NOSE AND THROAT AFFECTIONS.—Robert Levy, of Denver, in a paper read before the American Laryngological, Rhinological and Otological Society, calls attention to the interdependence of diseases of the stomach and intestines and those of the mouth, nose and throat, and emphasizes the necessity of recognizing this relation in the treatment of individual cases. Purely local treatment in certain nose and throat affections fails very often on account of neglect to search for the real cause of the trouble, and the administration of appropriate internal medication. Among the nasal affections of this character are vasomotor rhinitis, nasal irritation and red nose. Urticaria of the throat, hyperaesthesia and spasmodic laryngitis are frequently due to digestive irregularities.

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,, Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

MINUTES (*Continued from October Number*).

AFTERNOON SESSION, MAY 9, 1905.

Upon motion duly made and seconded, Dr. Silvio von Ruck was made a guest of the society.

MORNING SESSION, MAY 10, 1905.

The Secretary stated he had some matters that ought to be taken up at once, inasmuch as the nominating committee would have to make additional nominations on account of two officers resigning.

The resignation of Dr. Perkins as a delegate to the American Medical Association was read. On motion same was accepted.

The resignation of Dr. A. G. Friedrichs as councillor for the First Congressional District was read. On motion same was accepted.

Dr. Oscar Dowling rose to a question of personal privilege, stating that the Committee on Exhibits had denied space to the preparations of the Manhattan Eye Salve Co. cn the grounds that these were non-ethical products. Discussed by Drs. LeBeuf, Dempsey and Fenner.

Dr. Fenner moved that a committee of three be appointed by the President to investigate and to report at the meeting to-morrow. Motion seconded and carried.

The President appointed the following committee: Dr. E. D. Fenner, Dr. N. K. Vance, Dr. H. D. Bruns.

Motion was made that the program for the morrow be so altered that the discussion of legislative matters be taken up at 11:00 o'clock, as some of the members of the Board of Medical Examiners and of the Legislative Committee would not otherwise be able to be present. The President stated, if there was no objection, he would rule that these matters be the order of the day for 11:00 o'clock next day.

Minutes of the preceding day were read and adopted.

On his own request, Dr. Martin was allowed to exhibit a patient, and Dr. Granger made some remarks upon the case.

The report of the Nominating Committee was then read by the chairman, as follows:

We, the Nominating Committee, recommend for President, Dr. C. J. Ducoté, of Avoyelles; First Vice-President, Dr. J. F. Oechsner, of Orleans; Second Vice-President, Dr. J. J. Ayo, of Lafourche; Third Vice-President, Dr. D. R. Sartor, of Richland.

For Councillors: Second District, Dr. E. J. Graner, of New Orleans; Third District, Dr. H. L. Ducrocq, of Lafourche; Fourth District, Dr. N. K. Vance, of Caddo; Fifth District, Dr. R. F. Harrell, of Lincoln; Sixth District, Dr. C. M. Sitman, of St. Helena; Seventh District, Dr. C. A. Gardiner, of St Landry.

For Delegates to the American Medical Association: Dr. J. M. Barrier, of Richland, and Dr. Charles Chassaignac, of Orleans. Alternates, Dr. F. A. Larue, of Orleans, and Dr. E. Lee Henry, of Rapides.

For Members of the State Board of Medical Examiners: Dr. E. L. McGehee, Sr., and Dr. M. J. Magruder, both of Orleans, for Second District.

Place and date of meeting for next year, New Orleans, second Tuesday of May, 1906.

We recommend the voting of an honorarium of $500 to Dr. P. L. Thibaut for his services as Secretary; also one of $25 to Mr. George Augustin, Assistant Secretary. Respectfully submitted,

R. F. HARRELL, Chairman.

Dr. Fenner moved that the report be adopted as read.

Dr. Guthrie moved that the officers be elected *seriatim.*

After some discussion, which was participated in by Drs. Fenner, Guthrie, Hagaman, Harrell, Thornhill and Littell, Dr. Fenner withdrew his original motion and moved that the report be accepted and the names be voted upon *seriatim.* Carried.

Moved that the Secretary cast the ballots for each of the officers nominated. Carried.

Moved that the recommendations of the Nominating Committee as to the date and place of next meeting and the voting of an honorarium to the Secretary and one to the Assistant Secretary be approved. Carried.

The society then took up the special order of the day.

Dr. Ayo read resolutions passed by the council in general meeting with the Board of Medical Examiners.

Dr. Barrow, President of the State Board of Medical Examiners, read the following report:

At the last meeting of this society certain amendments were offered which, if they had been enacted by the legislature, would have enabled us to carry out the law. That law failed to pass because the physicians of Louisiana did not care anything about it—or at least not enough to lend it their active support. They all talked about it, but they would not do anything to help us to carry it. With the exception of your President and the physicians in Baton Rouge and members who are members of the legislature, we received no help whatever.

The osteopaths were there in force, and the Christian Scientists were there in force. It was a most humiliating thing for us to admit that we are more insignificant than osteopaths and Christian Scientists. We were the most insignificant people in that legislature. We succeeded in breaking up the opposition by making certain concessions. The bill died for lack of interest. It passed the house and went to the senate, where it died. Our object now is to get this matter into the hands of every member throughout the State, so that every member may help us.

I will call your attention to a few of the provisions of the law: The first thing relates to what practice is. According to the present law as interpreted by the courts, we are absolutely helpless to reach those classes of people whom we consider as violating the law. The courts say they are doing nothing. This new law is drawn up so that these people can be reached. For instance, we see in the papers daily where a Doctor So-and-So states in his advertisements that he is a world-renowned specialist. As a matter of fact he is not even in this city. These "doctors" take some student out of some college, and call it Dr. Blank's office. Now what we propose in the new bill is that that doctor shall do what he professes to do.

The next point is in regard to midwives. They can now do anything they want to do. The chief trouble in these cases is that under the special laws governing the subject we have not enough money to prosecute these cases. The cases simply stack up, and there is no money available to be used in prosecuting them. Sometimes we have given up our own salaries for this use, but that was not enough. We should turn these over to the District Attorney to prosecute, as other misdemeanors are prosecuted, giving power to the board to compel him to do it.

The next thing is in conformity with the idea that we should have reciprocity with the societies of other States. I have recently returned from the meeting of the Educational Council of the American Medical Association. The American Medical Association has decided to take up the matter of medical education. They have appointed a committee for this purpose. They will make a report, and possibly there will be some informal requirements, so that this association can put the stamp of its disapproval on a school if it is not doing proper work.

The other members of the board will make some remarks, from which you can get a better idea of what we need.

Dr. Vance then spoke as follows: The President of the Board of Medical Examiners has gone into the merits of the case. I will speak of the necessity of such a law in a general way. I will say for myself that I never realized the need of such a law until I became Councillor for my district. Then matters were brought to my attention. Violations are very numerous, and affect directly the physicians in the country. These physicians realize as never before the need of help in ridding themselves of charlatans, and of drug stores which are coming more and more to be dispensaries of patent nostrums which are injuring the public health, and also interfering with the physician's work. The best way of surmounting and overcoming this difficulty will be for all the members in their various parishes to appeal to their legislators to pass a law which will give the needed relief.

We are now organized in forty-seven parishes out of fifty-nine, and we can surely get what we want, if we will ask for it. The cause of failure heretofore has been due to apathy. If we will put our shoulders to the wheel we will get it. I think the country members ought to start to work on this when they go home. Discuss it freely; make it a matter of education, and we will get it through at the next legislature.

Dr. Smart spoke as follows: During the sitting of the last legislature the bill recommended by this society was introduced by myself. It was late in the session before it was presented to me. The committee of which I was chairman took it up at once. We had Dr. Barrow before us. The osteopaths came before us complaining of the bill; amendments were made to their satisfaction. The bill was reported favorably. Pretty soon telegrams began coming in from Christian Scientists. Then the bill was recommitted, as many of my friends told me they would not support it otherwise. The friends of the bill thought it expedient to give the Christian Science people a hearing. Dr. Barrow was always on hand, and the President. Through friends of the bill and amendments which we had made we thought we had eliminated all objectionable features, and had silenced all opposition. There was something of an undercurrent going on of which we had no knowledge, and the bill, after passing the house, was finally defeated in the senate. I do not believe it would have been had it come up at an earlier date. There was barely a quorum when it came up for the final vote. There will be opposition again. I wish to emphasize the remarks made by Dr. Vance that every physician should interest himself and urge the members in his section of the country to support the bill. It would, in my opinion, be a good idea for each and every member to visit the capital during this sitting of the legislature, for I am quite sure you will find opposition. I cannot but believe that it can be overcome if you will stand by us. I hope so, at least, and can assure you that I intend to use every energy and every ability, as I did before, to get this bill passed.

Dr. Powers made the following remarks: You have heard the bill pretty well discussed and the ground pretty well covered, with the exception of one thing about which I shall try to give you my ideas. What will it take to put this bill through? You say that the bill failed for lack of interest in the medical profession. Just the moment that the bill came up the Christian Scientists and osteopaths were heard from; they were aroused from one end of the State to the other; from every nook and corner; wherever there was an osteopath or a Chrisitan Scientist he was heard from; telephones, telegrams, letters; but we never heard anything from the physicians at all. The bill was first handed to me by Dr. Smart, who asked if I would handle the same through the legislature. I decided that Dr. Smart would be the better man to do so, and insisted, as I was a new member of the house. We did the very best we could for the bill, and in spite of the opposition we thought we were going to get it through on account of the concessions made. If this bill is to come before the house again it is my opinion that you should give the committee that has it in charge the right to make any concessions which may be necessary, or else we will have to make a fight, and you will have to stand behind us. I think every medical society should send a delegation to Baton Rouge to lobby, and to be there to see that the bill goes through. It ought to be understood that in case of opposition from any senator or representative, every physician in his district would send him a telegram or letter insisting upon the passage of the bill. The average legislators pay no attention to the bill; they will trade if they can gain anything personal. In order to overcome this you must let them know it will not do. There are many good men there; some that you can rely upon. The only way to get this through is to take hold of it and push it. Let every parish medical society in the State have a committee of one or more to lobby before the legislature; let every physician who is a member of the society be prepared to bring his influence to bear on his representatives. I think we can then get the bill through. I would like to have you consider this seriously, because this is the last time we will have an opportunity to discuss it, and we want to push it.

Dr. McVea.—I believe I am the only member present of the committee that was supposed to look after the bill. Dr. Smart did me an injustice unintentionally. He said that there was a member in the city who left without seeing the committee. I was there at the time. I communicated with Dr. Barrier and kept him and the other members posted about the bill.

It was not the opposition that killed the bill finally; it was the misunderstanding which was ridiculous. Mr. Griswell said if that bill passed it would be impossible for a person to get his eye-glasses mended without first getting a prescription from a physician. Mr. Dymond voted against the bill because of this. One or two of the representatives from New Orleans voted against the bill. Mr. Wilbert, of Iberville, voted against the bill, saying it was a malicious bill. I asked him why, and he said it would make it impossible for one to get his glasses mended without a prescription. This gentleman voted against the measure after it had come out of the committee, reported unanimously. We had quite a time getting the committee to report the bill. It was reconsidered on July 5, 1905. When it came up again, several gentlemen changed and voted for it. When the final vote came, there were a number of the members absent, and we were short but one vote, but could not get it.

Now, gentlemen, all of these men who voted against this bill reside in the country, except two. It is supposed that the country members are easier to reach than are the city members. If the members of this society will get a copy of this bill early and familiarize their representatives and senators before they go to the legislature, it will then be much easier. It was opposed on such flimsy excuses as above. If we had had a full attendance in the senate we would have passed it.

The best thing for each of us to do when we go home is to look up our representatives in the legislature and get them familiar with it, and then we will have no trouble.

Dr. Thornhill—I would suggest that it would be a good idea for each parish society to appoint a committee and to formulate a resolution, signed by each member of the society, and have them served on the different representatives in the legislature before they leave home, demanding and requesting that they support this bill. In that way an amount of personal influence could be brought to bear that could hardly be overlooked.

Dr. Chassaignac—It would have been humorous if it had not been such a serious matter. There was one senator who favored the bill and voted for it, but when the senator who had the bill in charge saw that it would be defeated, and voted "nay" in order that he might move a reconsideration, this senator who had voted for the bill then took the other side, saying that he had been thrown down by the very man who had asked him to support the bill. He said he would be blanked if he would be caught that way again.

Dr. Dowling—If such is in order I would suggest that we call for volunteers to go to Baton Rouge. I heard Dr. McVea call the names of three men who are personal friends of mine. I am sure that if we could bring sufficient pressure to bear we could induce them to vote for this bill.

Dr. Menville—I think this bill is one that should interest every one of us. Let us bear in mind, however, the old saying that what is everybody's business is nobody's business. I once asked a man what was the meaning of success. He said it was force. I asked him what force was, and he said that the first thing was money; the second thing is money; and the third thing is money. In order that we may make the proper arrangements, we ought all of us to put our hands down into our pockets and show how much we are interested.

This lobbying is all very well, but the country physicians, as well as the city physicians, may not have time to spend ten or fifteen days and lobby, but could not that be accomplished by us going down into our pockets and arranging for two or three good speakers to go over the State to explain the bill, have them call together the parish medical societies, and get the legislators there to explain the bill to them, explain to them the objects and show them where the objections are ridiculous? When these legislators get educated as to the nature of the bill I think we will need very little lobbying when the time comes to pass it.

After some further discussion, which was participated in by Drs. LeBeuf, Graner, Barrow and Barrier, Dr. LeBeuf moved as follows:

That the Louisiana State Medical Society set aside $300 dollars, to be used by the officers to the best of their judgment in this campaign of education. Carried.

(To Be Continued.)

The President has appointed the following Chairmen of Sections and openers of discussion for the 1906 meeting:

General Medicine.—Chairman, Dr. F. M. Thornhill, Arcadia. To open discussion, Drs. Hamilton P. Jones, of New Orleans, and A. F. Barrow, of St. Francisville.

SURGERY.—Chairman, Dr. J. D. Bloom, New Orleans. To open discussion, Drs. J. T. Bringier, Burnside and T. E. Schumpert, Shreveport.

NEUROLOGY.—Chairman, Dr. Clarence Pierson, Jackson. To open discussion, Drs. L. L. Cazenavette, New Orleans, and W. E. Kittredge, Napoleonville.

MATERIA MEDICA AND THERAPEUTICS.—Chairman, Dr. J. T. Halsey, New Orleans. To open discussion, Drs. Charles McVea, Baton Rouge, and S. K. Simon, New Orleans.

DISEASES OF CHILDREN.—Chairman, Dr. L. Abramson, Shreveport. To open discussion, Drs. G. King Logan, New Orleans, and F. H. Carruth, Lobdell.

OBSTETRICS AND GYNECOLOGY.—Chairman, Dr. Randell Hunt, Shreveport. To open discussion, Drs. Paul Michinard, New Orleans, and T. L. Mills, Jr., Baton Rouge.

GENITO-URINARY DISEASES.—Chairman, Dr. S. P. Delaup, New Orleans. To open discussion, Drs. C. Menville, Houma, and Jules Lazard, New Orleans.

DERMATOLOGY.—Chairman, Dr. J. F. Buquoi, Colomb. To open discussion, Drs. Isadore Dyer and J. N. Roussel, New Orleans.

OPHTHALMOLOGY.—Chairman, Dr. H. D. Bruns, New Orleans. To open discussion, Drs. F. E. Girard, Lafayette, and Oscar Dowling, Shreveport.

OTOLOGY.—Chairman, Dr. Homer Dupuy, New Orleans. To open discussion, Drs. C. J. Landfried, New Orleans, and J. A. Caruthers, Baton Rouge.

MEDICAL JURISPRUDENCE.—Chairman, Dr. Philip Asher, New Orleans. To open discussion, Drs. E. S. Matthews, Bunkie, and Allan Eustis, New Orleans.

SANITARY SCIENCE AND QUARANTINE.—Chairman, Dr. F. J. Mayer, Scott. To open discussion, Drs. John Callan, New Orleans and B. O. LeBlanc, St. Gabriel.

MARITIME AND INLAND SANITATION (Sub-Section).—Chairman, Dr. S. L. Theard, New Orleans. To open discussion, Drs. J. N. Thomas, Quarantine, and G. Farrar Patton, New Orleans.

BACTERIOLOGY.—Chairman, Dr. John J. Archinard, New Orleans. To open discussion, Drs. O. L. Pothier and J. D. Weis, New Orleans.

ANATOMY AND PHYSIOLOGY.—Chairman, Dr. A. R. Trahan, Lafayette. To open discussion, Drs. Henry Bayon, New Orleans, and B. A. Colomb, Union.

ORAL SURGERY.—Chairman, Dr. Samuel Logan, New Orleans. To open discussion, Drs. Emil Regard, Mansura, and Wm. M. Perkins, New Orleans.

X-RAY AND ELECTRO-THERAPEUTICS.—Chairman, Dr. Amédée Granger, New Orleans. To open discussion, Drs. N. F. Thiberge, and Gustav Keitz, New Orleans.

Medical News Items.

THE INTERNATIONAL TUBERCULOSIS CONGRESS, at its meeting held in Paris, France, October 7, decided to hold its next meeting in Washington, D. C., in 1908.

AT THE MEETING OF THE TRI-STATE MEDICAL SOCIETY, held in Chattanooga, Tenn., September 26-28, Dr. A. B. Cooke, of Nashville, was elected president, and Dr. Raymond Wallace, of Chattanooga, secretary.

THE THIRTY-SIXTH ANNUAL SESSION OF THE MEDICAL SOCIETY OF VIRGINIA will be held in Norfolk, October 24 and 27.

THE NEXT MEETING OF THE STATE BOARD OF MEDICAL EXAMINERS will be held at Tulane Medical College, November 14 and 15. This meeting was postponed from October 20 and 21 on account of the quarantine restrictions.

THE FIRST COMMENCEMENT EXERCISES OF THE ALEXANDRIA SANITARIUM AND TRAINING SCHOOL FOR NURSES took place October 3, and there were three graduates. Dr. G. A. B. Hays made the commencement address.

THE CITY HOSPITAL OF MOBILE, ALABAMA, will establish a training school for nurses at an early date.

THE GRADUATING EXERCISES OF THE TOURO INFIRMARY SCHOOL FOR NURSES occurred September 30, and twelve young ladies received diplomas. Rev. Dr. Beverly Warner made the address.

LITTLE ROCK, ARKANSAS, HAS A COLORED INFIRMARY with charity wards. It expects to be supported by public donations.

UNDER A DECISION RENDERED BY THE COMMISSIONER OF INTERNAL REVENUE every druggist, who, after December 1 of this year, may sell certain so-called patent medicines having whisky or other distilled spirits as the chief ingredient, will be obliged to pay a special tax to the Government as a liquor dealer. The manufacturers of these medicines will be required to pay the special tax imposed upon rectifiers and liquor dealers.

DR. H. W. WILEY, Chief of the Bureau of Chemistry of Washington, says: "The inspection law and its regulations and enforcements have had a most salutary effect upon trade relations. We are getting in this country now better and purer goods, and the result will not be, as was expected, a diminution of the volume of trade, but, on the contrary, a large increase.

JUDGE SKINNER OF THE CRIMINAL COURT OF NEW ORLEANS has decided that the Pharmacy Law of this State is unconstitutional, null and void, in recently dismissing a case in which infringement of the law was charged. The case was appealed to the Supreme Court, and will be tried in November, and in the meantime the State Board of Pharmacy is deeply concerned in the final decision, as the law was framed by the ablest lawyers in the State.

THE TRI-STATE MEDICAL ASSOCIATION OF MISSISSIPPI, ARKANSAS AND TENNESSEE will meet in Memphis on November 21, 22, 23. This meeting is expected to be the largest and most interesting that the association has held, and all eligible physicians in the States comprising the association are invited to be present. A rate of one and one-third fare will be made from all points in Mississippi, Arkansas and Tennessee. The Secretary, Dr. Richmond McKinney, of Memphis, will supply any information concerning the meeting.

PERSONALS: Dr. Warren S. Bickham's present address is No. 448 Madison avenue, New York City.

Dr. M. Feingold has returned from Europe.

Dr. J. F. Oechsner is enjoying a vacation in North Carolina.

Dr. L. Sexton attended the meeting of the Academy of Railroad Surgeons in Chicago, October 9.

Dr. Isaac Ivan Lemann, who has been traveling in Europe for the past year or more, is expected home.

Dr. Arthur B. Reynolds, of Chicago, has accepted the position of Medical Director of the French Lick Springs Hotel, at French Lick, Indiana.

Passed Assistant Surgeon M. J. Rosenau, of the U. S. P. H. and Marine Hospital Service, who had been detailed in New Orleans for special duty in connection with the investigation of yellow fever, has returned to Washington. Passed Assistant Surgeon Joseph Goldberger, who had reported to Dr. Rosenau, is still here.

MARRIED: On Thursday, September 7, at Butte, Montana, Dr. James Thomas Jelks to Miss Isabelle Catherine McKaskle. They will reside in Hot Springs, Arkansas.

DIED: Dr. D. C. Anderson died at Tallulah, La., on September 27, 1905. Dr. Anderson, who was a graduate of Tulane Medical Department, and at one time an interne of Touro Infirmary, was well known in New Orleans, and his death, occurring as it did, in a gallant fight against yellow fever, was deeply felt by all who knew him.

Dr. Z. T. Young, of Ville Platte, La., died October 4, aged 56 years. He was shot by the son of Dr. E. Thompson.

Dr. G. E. Martin, of Belcher, La., died October 6, at Roane, Texas, where he had gone for his health.

Dr. Charles M. Shanely died of yellow fever at his home near Barataria on October 9. Dr. Shanely had recovered from a mild attack of fever, and although urged by his friends not to take any risks returned to his post of duty and had a relapse.

Dr. Ben H. Brodnax, aged 73 years, died at Brodnax, La., on October 17.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Manual of Diseases of the Nose and Throat, by CORNELIUS GODFREY COAKLEY, A.M., M.D. Lea Bros. & Co., New York and Philadelphia, 1905.

This book reflects credit on the author and publishers in the selection and arrangement of the text and the typographical technic. Among many instances of excellence may be mentioned the cut showing the relation of the laryngoscopic image to the prepared specimen and the painstaking explanation accompanying it. The advices to use ether and chloroform in the adenoid operation we cannot endorse. The articles on atrophic rhinitis and the sinuses appear to lack some important details lately developed. As a whole it is a creditable example of a class of books necessarily abridged and incomplete, but capable of advantageous service especially in class room preparation. De R. & K.

The Urine and Feces in Diagnosis, by OTTO HENSEL, Ph.G., M.D., and RICHARD WEIL, A.M., M.D., in collaboration with SMITH ELY JELLIFFE, M.D., Ph.D. Philadelphia. Lea Bros. & Co., 1905.

The practitioner in search of a reliable guide can depend upon this publication.

On the important question of the preservation of urine, we read that of the drugs recommended for the preservation of urine the best is thymol. We wish to concur. The objection against chloroform is that it settles to the bottom and mixes with the sediment. Formalin is unsuited since it interferes with too many important reactions. We quote: "No matter what the preservatives, especial care must be taken with the sugar reaction, and several tests should be used as control."

It is pointed out that three of the tests most generally used for the detection of sugar in the urine by the average physician—*i. e.,* Nylander's, Fehling's and Trommer's—are open to objection, since a number of other foreign substances may give a partial reduction and leave one in doubt as to whether traces of glucose are present.

While the polariscope presents the simplest means of detecting the presence of sugar the cost of the instrument precludes its general use by the profession. As pointed out by the authors, the fermentation test is the only absolutely certain one.

An observation of Hallaner on the behavior of albuminous urines is worthy of careful consideration. He says: "If normal urine is concentrated on the water-bath to half its volume and albumin then added the boiling test will be strongly positive, but the ring and ferrocyanide test absolutely negative. As soon as water is added a turbidity will appear. If the urine is still further concentrated to one-fourth its volume, even the boiling test will be negative. The substances which interfere with these reactions are: For the ring test, urea; for the boiling test, urea and neutral salts, and for the ferroncyanide reaction, the phosphates. It is thus necessary to dilute concentrated urines before testing. This applies also to urines rich in urates."

One of the simplest tests for albumin is performed by adding a pinch of sulpho-salicylic acid to a few c. c. of clear urine in a test-tube. In the presence of albumin, a turbidity or white precipitate will form at the bottom of the tube. As a bedside test this should appeal to the busy practitioner.

A cut of Beckmann's apparatus for cryoscopy is shown and the procedure is described.

The possibility that the student of plant histology may be able to obtain valuable information from microscopic examination of the feces is pointed out. The rare combination of gastro-enterologist and histologist is deplored.

Comment is made on the so-called Nothnagel's bodies found in the feces which, instead of being composed of mucus, as Nothnagel thought, have been shown by Schorlemmer and by Schmidt to be composed of albumin. The fact, however, that the bodies are generally embedded in small shreds of mucus and are colored with bilirubin lends them the diagnostic significance attributed to them by Nothnagel, namely, of an ileitis.

A chapter on animal parasites is replete with information. The chemical examination of the feces, while not exhaustive, gives ample information.

We consider this work the best of its kind that has come into our hands in a long time, and wish it all the success that its able authorship merits. STORCK.

Practical Dietetics, by W. GILMAN THOMPSON, M.D. D. Appleton & Co., New York, 1905.

In the year 1895 the first edition of this book appeared, and it immediately won recognition as a standard among works of its kind. Each succeeding edition has been an improvement on its predecessor, and it continues to hold front rank among works of its character. It is an old friend of ours, and we commend it to the profession as a safe guide on a branch of therapeutics too illy understood by the average practitioner.

STORCK.

Moustiques et Fievre Jaune, by DRS. A. CHANTEMESSE and FREDERIC BOREL. J. B. Bailliere & Son, Paris, 1905.

This is an instructive monograph, particularly interesting at the present time, as it deals with the study of the relation existing between the subjects of yellow fever and mosquitoes in various parts of the world. Reference is made to past epidemics in Europe and many points are brought out which were difficult to understand at the time of their occurrence, but which are now clearly explained by the mosquito transmission of yellow fever. Maps are presented which delineate what are considered *infectable* territories, as well as those which have already at different periods been infected. A glance will suffice to show that we of the Southern United States are not by far the only ones interested in the destruction of mosquitoes, especially considering the constantly increasing rapidity of travel. The book is worth reading and having. C. C.

Pharmacology of the Fluid Extracts in Common Use, by JOHN S. WRIGHT.

This little treatise presents in a clear and comprehensive manner the salient points regarding the class of preparations of which it treats, and forms a fit companion to the author's work on the organic drugs of the United State pharmacopeia. STORCK.

Publications Received.

F. A. Davis Co., Philadelphia, 1905.

Practical Massage in Twenty Lessons, by Hartwig Nissen.

P. Blakiston's Son & Co., Philadelphia, 1905.

A Text-Book of Chemistry, by William Russell Jones, M. D.
Microtomist's Vademecum, by Arthur Bolles Lee.
Quiz Compends: Histology, by Henry Erdmann Radasch, M. D.
Materia Medica and Pharmacy, by Reynold Webb Wilcox, M. D.
Manual of Operative Surgery, by John Fairbairn Binnie, M. D.

Lea Bros. & Co., New York and Philadelphia, 1905.

National Standard Dispensatory. Hare-Caspari-Rusby.
A Manual of Diseases of the Nose and Throat, by Cornelius Godfrey Coakley, M. D.
Progressive Medicine. Hare-Landis. Vol. III, No. 3. September 1, 1905.
Medical Epitome Series. Practice of Medicine. Dayton-Pederson.

D. Appleton & Co., New York and London, 1905.

The Principles and Practice of Medicine, by William Osler, M. D.

Miscellaneous.

Moustiques et Fievre Jaune, par A. Chantemesse et Frederic Borel, Docteurs de Medicine. (Librairie J. B. Bailliere et Fils, Paris, 1905.)
Elements of Homeopathic Theory, Materia Medica, Practice and Pharmacy, by Drs. F. A. Boericke and E. P. Anshutz. Boericke & Tafel, Philadelphia, 1905.
U. S. Department of Agriculture—Soil Survey of the Long Island Area, New York, by J. A. Bonsteel and party. (Government Printing Office, Washington, 1905.)

Reprints.

Treatment of the Simple Fracture of the Arm and Forearm, by Dr. Henry H. Fulton.
Abstract of an Article on Vaccination and Serum Therapy Against the Bacillus of Dysentery, by Dr. Frederick P. Gay.
Congenital Anemia, by Dr. Ira B. Bartle.
Animal Remedial Preparations, by Dr. John W. Wainwright.
Dionin (Ethyl-Morphine Hydrochlorate) in Ocular Therapeutics; (2) *Is Keratitis Ever Caused by Rheumatism,* by Dr. Leartus Connor.
Historical Sketch of the Radical Mastoid Operation, by Ray Connor, M. D.
Blood Conditions in Rheumatism, by Ira B. Bartle, M. D.
Medical Ethics, by Dr. Nathan L. Clarke.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR SEPTEMBER, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	5		5
Intermittent Fever (Malarial Cachexia)		2	2
Smallpox			
Yellow Fever	102	9	111
Scarlet fever			
Whooping Cough	1	1	2
Diphtheria and Croup	4		4
Influenza			
Cholera Nostras		1	1
Pyemia and Septicemia	2	1	3
Tuberculosis	51	39	90
Cancer	16	4	20
Rheumatism and Gout		3	3
Diabetes	1		1
Alcoholism	5	1	6
Encephalitis and Meningitis	4	1	5
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	10	9	19
Paralysis	3	1	4
Convulsions of Infants	3	3	6
Other Diseases of Infancy	19	7	26
Tetanus	5	6	11
Other Nervous Diseases			
Heart Diseases	24	25	49
Bronchitis	5	3	8
Pneumonia and Broncho-Pneumonia	8	8	16
Other Respiratory Diseases	3	2	5
Ulcer of Stomach		1	1
Other Diseases of the Stomach	3		3
Diarrhea, Dysentery and Enteritis	15	17	32
Hernia, Intestinal Obstruction	4	1	5
Cirrhosis of Liver	8	1	9
Other Diseases of the Liver	2	1	3
Simple Peritonitis	1	1	2
Appendicitis		2	2
Bright's Disease	16	15	31
Other Genito-Urinary Diseases	1	4	5
Puerperal Diseases	2	6	8
Senile Debility	20	8	28
Suicide	3		3
Injuries	19	14	33
All Other Causes	4	9	13
TOTAL	370	206	576

Still-born Children—White, 33; colored, 26; total, 59.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 18.57; colored, 27.77; total, 21.26.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**29.96**
Mean temperature	**81.**
Total precipitation	**11.09 inches.**

Prevailing direction of wind, north.

New Orleans Medical and Surgical Journal.

VOL. LVIII. DECEMBER, 1905. No. 6

Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of this article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

The Kidneys and the Tongue in Yellow Fever.

By E. M. DUPAQUIER, M. D., Professor Clinical Therapeutics and Tropical Medicine, N. O., Polyclinic, New Orleans.

The prognostic importance of the renal function in all infectious or toxemic diseases is well known; thus, in pneumonia we now watch the kidneys closely, and we feel, as a rule, safely guided in our prognosis by their activity. But some toxemias affect the kidneys still more directly than others, for instance, scarlatina and yellow fever.

I am not referring here to the post-scarlatinal nephritis occurring after the subsidence of the acute symptoms, but to the nephritis appearing early, during the first week. In severe cases this scarlatinal nephritis is not simply transient. It is due to structural alterations and may terminate in death. Similarly in severe yellow fever nephritis means structural changes and, as a rule, death within the first week. In yellow fever, more commonly and more deeply than in scarlatina, the renal function is, from the outset, threatened and actually disturbed. Speaking of the kidneys as individuals, in yellow fever, we might use the words of La Fontaine, in his fable, *Les Animaux malades de la Peste:*

"Il ne mouraient pas tous, mais tous étaient frappés."

Indeed, the kidneys in yellow fever are always stricken. The renal function always bears a formidable part in the tragedy, so much so that in every case from the start we silently put this question to ourselves: I wonder how much the kidneys will be damaged?

The tongue of the patient, very properly, will answer this embarrassing question in many instances. It is a "red, raw-looking tongue, having a glazed surface studded with enlarged papillæ"; in other words, it is like, or very near like, the so-called strawberry tongue of severe scarlatinal toxemia. I have observed this tongue, on the fourth day, in yellow fever, also, and I have observed that it is of grave prognostic importance.

In a recent severe case we attended together I called the attention of my confrère, P. E. Archinard, who is very familiar with yellow fever, to this appearance of the tongue, and, while at the time, the fifth day of the attack, the renal function seemed most favorable, it began to fail late on the fifth day, and near the seventh day the patient died after suppression, coma, stertor, etc. I can recall other similar instances, and I am inclined to depend on this sign of the tongue as an index of a severe yellow fever toxemia, which will eventually either tell on the kidneys or on the nervous system to the extent of annihilation.

At the bedside of a case of yellow fever we all are perplexed and quite often dazed by the swiftness of the course, by the rush of the attack and chiefly by our sad deceptions in prognosis. As we look around for directions to see clear ahead, we ponder on diagnosis, morbid process, symptoms, examination of organs, social, family and previous history of the patient.

From this we perceive in the grip of a severe toxemia the whole of the organism, but, of all the parts, as a rule, we distinctly see the kidneys suffering the most. To them our attention is forced. All that affects them affects the prognosis, viz., overwork, privations, inherited predisposition, alcoholism, etc. The ominous prognostic value of the latter is illustrated here. See the kidneys* of a man who died on the third day of his at-

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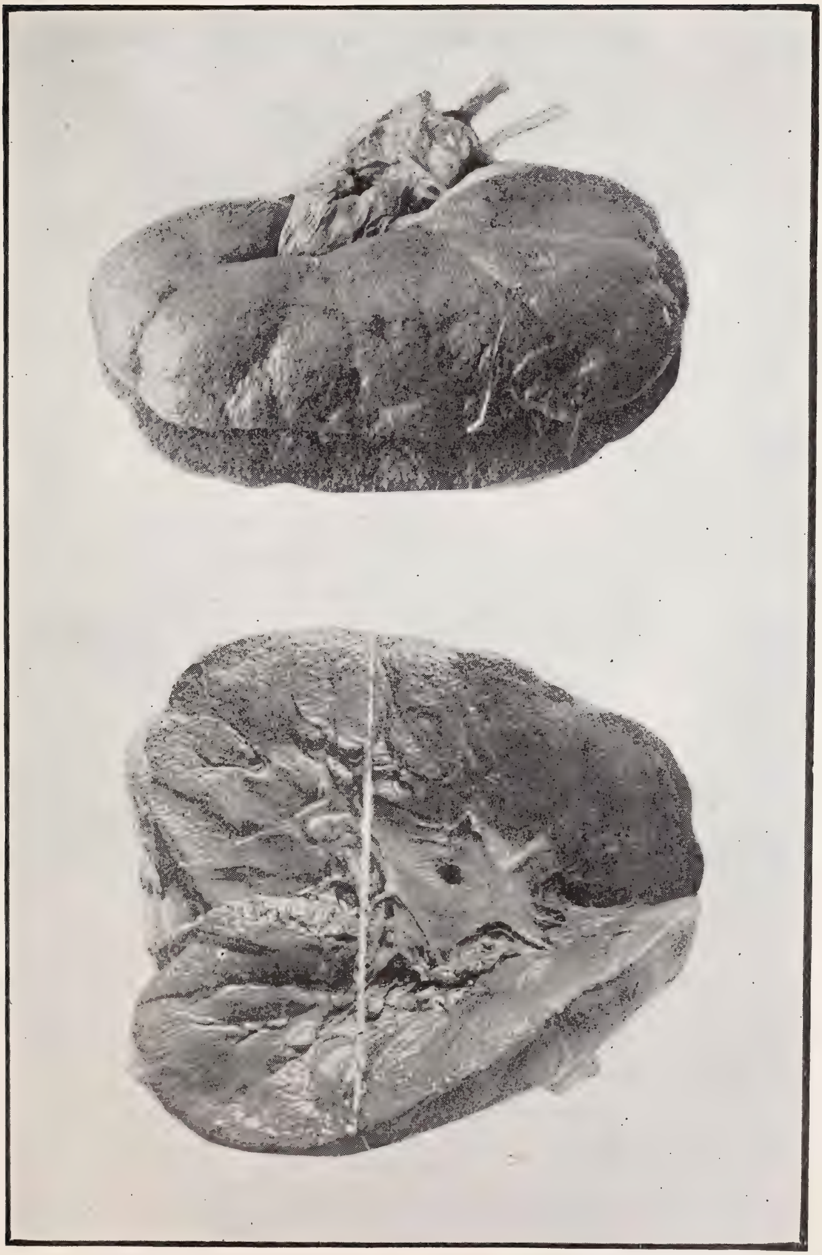
*One of the specimens of the laboratory of the Emergency Hospital procured through the kindness of Dr. P. E. Archinard.



YELLOW FEVER KIDNEY.
(Dr. Dupaquier's Article.)

tack of yellow fever at the Emergency Hospital. The previous inroads of alcoholism are shown on the cirrhotic external aspect and the fatty changes due to the toxin of yellow fever on the internal. And yet we never know positively how much the kidneys are actually damaged, for some of these doomed cases recover.

Now, I venture to say that by looking at the tongue in our embarrassment we might know. I repeat, a tongue that recalls the strawberry tongue in the fourth day of severe scarlatina indicates a toxemia, involving so much of the kidneys that they will be annihilated in a few days in yellow fever.

While recording the co-existence of the strawberry tongue and fast degenerative nephritis in scarlatina on the one hand, and, on the other, the co-existence of a similar tongue and fast degenerative nephritis in yellow fever, I am unable to explain the relation between the kidneys and the tongue in both toxemias. It is hard to prove that besides the appearance of the congested and inflamed mucous membrane of the tongue in both toxemias, attributed solely to the exanthem in scarlatina, there is a bearing on the actual disastrous condition of the kidneys. However, the fact remains that I have observed this well enough to justify the writing of the present clinical note.

Typhoid Fever in Country Practice.

By B. O. LeBLANC, M. Ph., M. D.

Health Officer of Iberville Parish and Physician to the Louisiana State Convict Farm, St. Gabriel, La.

In my belief typhoid fever is of much rarer occurrence than is generally thought by our local physicians, typical cases of typhoid being very seldom seen in these localities. The ordinary continued fevers of malarial origin are for the most part diagnosed enteric fever.

In the first place the typhoid bacilli do not exist here except in isolated cases that have probably been imported and that is generally the end of the disease.

The stools are thrown away and there being no general water supply into which the stools are washed no more cases are liable to occur.

In towns where the water supply is from one source, and in which there are cases of typhoid, an epidemic is liable to occur, as in Butler, Penn., in 1903, where the water supply of the town was derived from the Schuylkill River and where there were previously a few cases above the town.

As we get our water from cisterns there is hardly a chance of the bacilli getting into the water, as it is not known to circulate in the air; therefore, while there may be a case in a house, if the occupants are careful they may not contract the disease, nor will any one in the neighboring houses, even though they visit, if discretion is used. When we see a case it is generally traced from some watering place, where the patient has been visiting, or a trip to some town traveling on train, for we don't know where they get water for the passengers, or the ice may be infected. Although it may be possible for a patient to get infected through ice, raw oysters or town vegetables, I don't think the disease is contracted and spread thus here.

The cases of fever that we usually see set in rather abruptly with chill or chilliness and high temperature (103-104) at the first visit. Now we all know that a typical case of typhoid generally starts gradually and with low temperature (99-100), rising every day.

There are sometimes cases of mixed infection of malaria and typhoid in which the fever comes on suddenly and with high temperature, but if such is the case we would observe some typhoid symptoms, viz.: Strawberry tongue, diarrhea, epistaxis, gurgling in the right iliac fossa, prostration, delirium, and, above all, the most important, rose-colored spots on abdomen between the seventh and eleventh day.

After carefully examining every case of continued fever in practice I have failed to get any of the symptoms mentioned above, except one case, which I will make mention of in this paper.

These fevers, as stated above, generally set in abruptly with high temperature, which continues for from two to six weeks, and declines by lysis, leaving the patient usually on the same day that he was attacked, in the second, third, fourth, fifth or sixth week.

Admitting that typhoid comes on suddenly with high temperature, when there is mixed infection in malarial districts the absence of above mentioned symptoms ought to convince the physician as to the nature of the disease.

Another feature against typhoid is the death rate. In these fevers I have very seldom seen deaths in my practice, whereas in typhoid the death rate ranges from 7 to 20 per cent.

Have never seen hemorrhages from intestines in these cases, as often occur in enteric fever. The continued malarial fevers are usually cut short by the proper administration of quinin, whereas typhoid is not affected by this drug, except maybe to lower temperature through its antipyretic influence.

I admit, however, that some cases of malarial fevers are not much affected by quinin, for the simple reason that remittent malarial fevers are caused by the estivo-autumnal parasites, which during the first week or ten days are small, hyalin bodies, sometimes with one or two pigment granules, found in peripheral circulation. Now, during this time quinin affects and cures the disease, whereas after this time the parasites become crescentic, and this variety is known positively not to be affected by the specific.

Of the numerous cases of typhoid I saw at the New Orleans Charity Hospital during my college course, none coincides with my cases except the following, which I consider a typical case:

V. G., colored, male, aged 26; occupation, yardman; robust, weight 160 pounds. Family history very good. Personal history excellent, except measles during childhood. Physical examination: Heart, lungs, liver, kidneys normal. Was called to see patient October 15, 1904. His temperature was then 101 degrees and he gave history of having had fever two or three days before and general malaise and previous diarrhea, epistaxis. Temperature gradually rose for four or five days, with an evening temperature about a degree and a half higher than the morning remission, so that there was a temperature of 104 degrees at the end of first week. Ran a steady course during second and third weeks, with slight daily remission. During fourth week the fever began to fall by lysis and by the end of fifth week temperature was normal.

Of other symptoms there were gurgling in right iliac fossa, typhoid tongue, with sordes, abdominal pain and tenderness, with diarrhea in first part, prostration and delirium.

Treatment consisted in light mercurial purge at once, followed No intestinal hemorrhage.

Treatment consisted in light murcurial purge at once, followed by Epsom salts ℥ $\overline{\text{ss}}$. six hours afterwards. Quinin, twenty grains daily for a number of days, with no definite effect. Absolute liquid diet from beginning, which was kept up until ten days after temperature was normal. Liquid diet consisted of milk every three hours, strained soup and broth two or three times daily. Tablespoonful toddies three times daily.

In second week tablets of strychnin sulphate (gr. 1/50) every four hours for stimulating nervous system, and this was continued throughout the disease. Treatment was purely systematic—hydrotherapy for high temperature, astringents for diarrhea when it became too profuse.

After questioning patient, found that he had been visiting a settlement in the interior of next parish, where there was a large number of typhoid cases, and the people were getting water from surface wells.

There had been in the neighborhood of one hundred cases in that section within two months.

Being unable to get a blood examination, made a diagnosis from clinical symptoms.

This is generally the case with the general practitioner who has not time for examining specimens or is unable to keep cultures on hand. Hence, our diagnosis is for the most part made clinically. If we were able at all times to procure blood examinations from the pathological laboratories there would be no doubt as to the nature of the disease.

Louisiana State Medical Society Proceedings.

(EDITED BY PUBLICATION COMMITTEE).
P. L. Thibaut, M. D., Chairman.

Tetanus Statistics.

By J. D. BLOOM, M. D., New Orleans.

The disappointment that followed the use of tetanus antitoxin even by its early prophylactic administration vigorously pushed makes pertinent any fact in a personal experience that would contribute to our knowledge of method, dose or reliability of manufacture.

There seems to be no doubt that in the statistical showing of large numbers of cases a decided lowering of the mortality can be recognized by the serum's use. The central effect both of the tetanin and antitetanin that has prompted the intracerebral and spinal subarachnoid methods of the curative serum's use, and the belief that the subcutaneous introduction of the antidotal remedy conserves merely the prevention of a further general infection, is to be measured by entrance, route and central effect, and, while the central method of administration secures a more immediate promise of offsetting the active disturbance of the centers, it should not be argued in setting aside the curative dosage possible by a subcutaneous or intravenous administration.

So thoroughly impressed have I been by a little experience during my years of hospital work that the impression has gone into sufficient force to have me compile the Charity Hospital statistics for the past twenty-five years to negative or affirm my impression.

Four years preceding 1896 the number of cases treated had exceeded any four successive years of the breadth of these observations and the rate of mortality was equally of a high showing.

Dr. O. L. Pothier, pathologist, on the eve of his departure for the European laboratories, was requested to make arrangements for the regular shipment, quarterly, of a stock of antidiphtheritic and antitetanic serums of the Pasteur Institute, of Paris, of whose reliability and scientific precision I was confidently assured. The shipments followed in regular order and continued actively throughout the year that followed, when besieged by American manufacturers with an offer of such attractive financial benefit to the hospital I was persuaded to ask a release from the Pasteur contract.

My impression in the use of the Pasteur product, during the time covered by its use, was as happy as is the accepted outcome of the early use of the antidiphtheritic serum of today, and, in addition to the cases shown, I can recall a number treated by a like product with even more favorable result by my professional friends in the city with whom I was associated.

During the twenty-five years covered there were treated in the hospital 291 cases of tetanus, of which 226 died, a mortality for all cases of a little less than 78 per cent. Antedating the serum's full use, which was in 1896, the mortality by the prevailing method of treatment was 85 per cent plus, which included all cases and types. In the facts as presented, only the comparative results can be shown, as such data necessary to the effect of the remedy upon the type of infection, other than traumatic or idiopathic, cannot be definitely made.

It was about the middle of the year 1896 that the hospital began to use the Paris product, at first secured from agencies in the United States, and the impress of its use marks a contrast with the four preceding years.

The year 1891 shows an improvement by comparison in result, the outcome of the removal from the institution of three patients that passed out from under observation, the result remaining unknown.

In 1897, when the Pasteur serum use was made particularly exclusive, coupled with the sedative effect of bromide and chloral, the death showing was but 33½ per cent., the lowest in twenty-five years. I, too, can recall the small dose of bromide and chloral that was required after its use and the decided impression one and two doses of serum produced upon the disease.

In the seventeen years preceding the use of antitetanin the hospital treated 169 cases, with 144 deaths, a mortality rate of

85 per cent. plus. Since the serum's introduction, though not continuous use, the mortality has been 67 per cent. plus. The lack of its continuous use was occasioned by the apparent harmful effect of the product that replaced that from the Paris Institute, exhibited by a high temperature following its administration in every instance. This prompted its return to the manufacturers for an examination and an explanation. Their reply was to the effect that it could only be explained by the change of temperature from the place of its manufacture to that of this city. At any rate, this fear in its use was very gradually overcome by gradual and tentative use of the replacing product. The showing of this is made in 1899, when again the mortality reached 100 per cent., the highest mortality in the eight years of the serum's use, whereas in the seventeen preceding years this death rate had occurred seven times. In this there is a very convincing evidence of its therapeutic value in a general way and so markedly in the showing of the superiority of the Paris product, coupled as it is by the recollection of the marked amelioration and cure following one and two doses of 20 c. c. each in cases that I recall, that I beg to submit these facts in the interest of the sufferer for a further test and in the hope of its confirmation and influence upon our home manufacturers.

The statistics are here appended:

Tetanus.	Cured.	Im-proved.	Unim-proved.	Died	Total.	Death Rate.
1879.						
Tetanus	..	..	..	3	3	
Idiopathic	..	..	..	2	2	
Traumatic	2	..	..	4	6	
				9	11	81 9/11%
1880.						
Tetanus	..	..	..	8	8	100%
1881.						
Acute	..	..	1	4	5	
Chronic	..	..	..	1	1	
				5	6	83 1/3%
1882.						
Idiopathic	..	..	..	2	2	
Traumatic	..	..	..	6	6	
				8	8	100%

Tetanus.	Cured.	Improved.	Unimproved.	Died.	Total.	Death Rate.
1883.						
Traumatic	2	..	..	6	8	75%
1884.						
Idiopathic	1	..	1	3	5	
Traumatic	1	..	..	1	2	
				—	—	
				4	7	57 1/7%
1885.						
Idiopathic	..	..	..	1	1	
Traumatic	3	..	..	7	10	
				—	—	
				8	11	72 8/11%
1886.						
Idiopathic	..	..	..	3	3	
Traumatic	..	..	..	2	2	
				—	—	
				5	5	100%
1887.						
Idiopathic	..	..	..	2	2	
Traumatic	..	..	..	10	10	
				—	—	
				12	12	100%
1888.						
Idiopathic	..	..	..	1	1	
Traumatic	..	..	..	6	6	
				—	—	
				7	7	100%
1889.						
Traumatic	2	..	1	4	7	57 1/7%
1890.						
Idiopathic	1	..	..	..	1	
Traumatic	1	..	..	8	9	
				—	—	
				8	10	80%
1891.						
Idiopathic	1	..	..	..	1	
Traumatic	..	2	1	5	8	
				—	—	
				5	9	55 5/9%
1892.						
Idiopathic	..	1	..	1	2	
Traumatic	1	..	..	6	7	
				—	—	
				7	9	77 7/9%
1893.						
Idiopathic	1	..	..	1	2	
Traumatic	2	..	..	7	9	
				—	—	
				8	11	72 8/11%
1894.						
Idiopathic	..	..	..	1	1	
Traumatic	..	..	..	15	15	
				—	—	
				16	16	100%

Tetanus.	Cured.	Improved.	Unimproved.	Died.	Total.	Death Rate.
1895.						
Traumatic	..	..	..	24	24	100%
1896.						
Idiopathic	1	..	..	6	7	
Traumatic	5	1	1	8	15	
				14	22	63 7/11%
1897.						
Traumatic	10	..	..	5	15	33 1/3%
1898.						
Traumatic	2	1	..	13	16	81 1/4%
1899.						
Traumatic	..	..	..	14	14	100%
1900.						
Traumatic	2	1	..	10	13	76 12/13%
1901.						
Acute	3	..	..	3	6	
Traumatic	2	..	..	2	4	
				5	10	50%
1902.						
Tetanus	2	..	..	6	8	75%
1903.						
Acute	6	1	2	15	24	62 1/2%
Grand Total	51	7	7	226	291	77 193/291%

Septic Awakening by Chloroform General Anesthesia.

By J. D. BLOOM, M. D., New Orleans, La.

Advisedly has this title been taken in recounting an experience that it seems eminently proper that I bring forward for a greater consideration than seems to have been the disposition to accord it.

Truly, the microscopical and bacteriological progress has alone made possible a determination with any degree of accuracy. The fact that I would record a sepsis along the genito-urinary tract, that a personal experience has given impressions that I feel constrained to relate.

It is known that a vesical tonic has its effect by strengthening the detrusor urinæ and thus preventing retention and by strengthening the sphincter vesicæ and thus preventing incontinence.

While the center of the movement of the bladder is situated in the middle of the spinal cord, the activity of the center under normal conditions is modified by the brain, giving us both a cerebral as well as a spinal center for this organ.

When the urinary passages are healthy the secretion of mucus from them is very slight and the presence of urine in the bladder or its passage along the urethra usually gives rise to no pain. Scalding and pain are sometimes caused by abnormal acid urine, even though the mucous membrane itself is healthy. In such cases the remedy is very simple. When the organ itself is inflamed or irritable the secretion of mucus is increased and there is a constant desire to micturate.

The modification of the secretion of urine depends very closely upon the pressure of the blood in the Malpighian corpuscles; or, to put it more exactly, the difference of the pressure between the blood in these corpuscles and the pressure within the tubules. It is said that if the ureter is tied the pressure is decreased, the secretion is greatly diminished, and these are arrested, even though the pressure of the blood in the renal artery be high. A similar effect is produced by a ligature of the renal vein, for the blood accumulating in the plexus surrounding the tubules compresses them so as to prevent the flow of urine through them. A similar condition may occur from cardiac or pulmonary disease obstructing the venous circulation. The blood pressure in the glomeruli may be diminished by failure of the heart's action and by dilatation of the vessels of large areas. When the nerves of the kidney are cut the vessels dilate. The opposite occurs when they are stimulated. The vaso-motor center in the medulla is stimulated either by venous blood or by drugs. As a result there is a twofold action on the kidney, for it tends to cause contraction not only in the vessels of the kidney, but in other parts of the body. The effect upon the kidney is thus a complicated one, for the contraction of the intestines and other vessels raises the blood pressure, which tends to drive the blood into the kidneys at the same time that the contraction of the renal arteries tends to keep it out.

When the renal nerves are intact the result is a varying one, for sometimes contraction of the renal vessels may be so great as to prevent the entrance of the blood into the kidneys, however high the general pressure may rise. At other times the general high blood pressure may be able to dilate the renal arteries in spite of any resistance they may offer. The deduction from this is plain. Diuretics may act on the circulation or on the secreting cells.

Now, while chloroform in its employment is dangerous either by stoppage of respiration or by stoppage of the heart, in the majority of instances that I have witnessed the greatest danger, however, in the extreme sense, has been from the latter causation. This, together with its effect upon the nerve influence which in other instances is so unmistakable, makes pertinent the possibility for the occurrence of conditions that I desire herein to call attention to, and which, in so many instances unobserved, if continued to exist, have terminated the existence of an individual who lacked any previous history, either hereditary or acquired, other than the administration of a general anesthetic.

In this I refer more particularly to general anesthesia by chloroform, inasmuch as my experience has been more free with this drug. I recall, however, as many of you may, an instance of etherization that was followed by bloody urine and death, wherein the patient was suffering from a septic trouble that may have aggravated the genito-urinary symptoms through the septic influence existing.

The condition of the kidney which is known as a surgical kidney—in other words, a suppurative pyelitis, to which may be added one or many abscesses in the parenchyma, an infection in the organ—is possible through the blood or through the urethra. The former is known as the hematogenous infection; the latter the urinogenous. The kidney is one of the chief avenues for removing the germs from the body. As a result, it does not surprise one that these germs occasionally lodge and develop in its tissues. The urinogenous infection is most frequently represented by the gonococcus microbe.

The flow of urine in any manner obstructed greatly favors the development of bacteria. Renal suppuration is frequently represented in varying symptoms. It may develop after a cystitis or after an injury. If the normal secretion is obstructed in an inflamed kidney, the renal tissue will be destroyed with a greater rapidity than that which takes place in a hydro-nephrosis.

An abscess rupture in the renal pelvis, the pus being discharged through the ureter, may be followed by recovery. Occasionally pyuria will come on gradually and continue for a long time without pain, and it is of this class that I more pertinently beg to refer to in this recount.

In an instance of a case I very recently cared for, in which the suppurative condition had extended from the urethra up to the kidney, and in which case it was interesting to note how much thickened the bladder wall had become from the long continuance of the inflammatory process, the infection being a gonococcus one, the urethra showing a marked peri-urethritis and the muscular effort of the bladder being so great and of long continuance as to develop a thickness of at least three-eighths of an inch, sufficient to have it appear that the bladder was distended and persuading the interference of a supra-pubic cystotomy. After this was done the bladder was thoroughly irrigated, and, to my surprise, the muscular wall, as mentioned above, alone accounted for its apparent distention. It was very pretty to watch the trickling of the purulent fluid through the ureters after irrigation of the bladder was done, pointing very forcefully to the existence of a surgical kidney from which the patient was suffering. This was an individual of very loose and desperate habits and the condition could readily be accounted for by his acknowledged method of living. This is merely mentioned to point out the possible ascending of an infection from the urethra to the kidneys and to point the differential diagnosis of renal pyuria and purulent cystitis that would only be possible outside of the irrigation by cystocopic examination. Of course, in determining the location of the disease, the lesion, the source of infection and the condition which make the irritation suppurative are factors arrived at by carefully reviewing the history and by exhaustive study of the urine.

Prof. Senn's classification of cystitis is rather a full one, more so than is required at the bedside. Of course, the most modern ideas entertained as to the etiology place microbes in the first rank, relegating other causes to the credit of predisposing. Thus, it warrants us in considering well the identification of particular microbes which are at work, not only to emphasize the diagnosis, but to appropriate the treatment. It is well to note, too, that the bladder wall is tolerant of large numbers of microbes, that it can suffer a long time, harbor new growths and foreign bodies without any but slight protest; altogether injuries may excite only pathogenic microbes as the added essential to active inflammatory process. Prof. Senn's classification of bacteriological forms of infection are the bacilli coli communis infection, saprophytic "mixed" infection, staphylococcus and streptococcus and streptococcus erysipelatis infection, typhoid bacillus infection, diplobacillus infection, gonococcus infection and bacillus of tuberculosis infection.

Of course, the necessary exciting causes of the inflammation is the presence of a pathogenic action of microbes in the tissues. Pathogenic organisms may reach the bladder and ureter through the urethra, toward which the use of instruments plays a part. Clinical observations, together with microscopical examinations, prove that the urine from scarlatina, varicella, typhoid, septicemia and tuberculosis patients carries bacteria of the nature of the disease suffered from, being excreted by the healthy organ, uninjured, as it is, through the function.

Inflammation of the kidneys often precedes that of the bladder, but it greatly enhances the danger of the bladder infection. Among the causative influences—that is, the predisposing one in the instance that I speak of and which plays the active part in the expression of this form of sepsis—is a *locus minoris resistentiæ* in the tissues of the organs in which pathogenic microbes of sufficient virulence have accumulated to produce the necessary changes.

In simple words, I beg to mention the cases that have biased me in the consideration of this matter, and that at this writing four of recent observation have impressed me.

The first case was that of a wife of a physician, upon whom I did a uterine curettage for a condition that was not septic and in which an analysis of the urine showed a normal condition. Following the operative interference, which I may say was not followed by any temperature rise, a marked condition of genito-urinary sepsis was awakened. This continued for quite a time, long after apparent convalescence had in a visible way been acquired. The continuance of the condition prompted the advisibility of having the patient go to Waukesha, so as to indulge in water drinking, with the purpose of diluting the infection. I am pleased to say, at this writing, no evidence exists, though the condition covers a space of very nearly two years.

The two cases that followed were appendiceal infection, both of virulent type. In one, a young boy of sixteen, prior to the operative interference for which the secretion had been obtained, the report showed no septic condition. The operative interference, which was, in a measure, extensive, as an appendix had ruptured, and there was peritoneal fecal extravasation, with a reactionary result, which was, of course, expressed in abscess formations. After this the genito-urinary sepsis was awakened and continued long after every evidence in the local wound, which was treated by the open method, was healthy. Temperature rise existed sufficient to be annoying and was only interpreted as that due to a genito-urinary infection, confirmed, as it was, by the urinalysis, which was made daily. In this instance, after two and one-half months of hospital confinement and treatment, which was, of course, by urinary antiseptics, the condition began to abate by evidence shown in the urinalysis and by the discontinuance of the temperature rise. The boy was in the institution four months and had a fecal fistula that contributed to his detention, but, at this writing, he is perfectly sound and well with a urinary report that in every manner has an appearance of a permanent result of good.

The other case of appendiceal infection was one that was brought into the institution after a week's illness, a female of the age of twenty-eight, with temperature rise and a mass in the right iliac region. Operative interference was practiced, with the finding of an abscess and ruptured appendix, both of which were carefully removed, and the peritoneal toilet safely made, the wound being allowed to remain open. While the urine examination upon the admission showed nothing that might warrant alarm, this patient died at the end of the third day of convulsive seizures and urinary suppression; the abdominal symptoms being absolutely without pathological evidence. In the report of the urine that was obtained, pus and albumen were in the greatest abundance.

The fourth case was that of a young woman of twenty-five years, with fracture of both patellas displaced in such a way as to require operative interference, both bones being operated upon at one sitting. The condition of her urine prior to the operative interference was perfect in a general way. The day following the operative interference a marked vesical tenesmus, associated with a slight temperature rise that continued, gave quite a perplexing appearance to her condition. At the end of the first week the urine was in appearance almost one-half of purulent showing. This was further confirmed by the pathological report and continued so for nearly two and one-half months. She gradually improved from that time on, the urine returning to normal, pus having entirely disappeared, and her health improved notably. We began to feel confident of her ultimate recovery, as the local wound had no showing of a septic character. The bony union apparently perfect, she was wheeled daily out into the sunlight and put on tonics, when, two weeks prior to the termination of her condition, she was taken with sudden general discomfort, temperature and mental dullness, and it prompted a re-examination of her urine, which proved a lighting up again of the pyelitis that had previously existed, producing an impairment in the excretory effect of the kidney from which a uremia followed, producing death after a confinement of four months, interspersed as it was by a promising instance of a hopeful and perfect recovery. This is an instance of a primary vesical infection that ascended to the kidney. This can, of course, be stated from the history as given and from the urinary examination. The other instances were of primary pyelitis, a marked contrast in the showing of a least resisting point along the genito-urinary tract. These instances pertinently outline guides that are worthy of our respect in considering the outcome of individual cases, the character of the anesthetic used, the amount given, the method of administration and the need of watchfulness for its secondary effect, plus the septic condition for which operative interference is practiced. In none of the cases recorded was a catheter used.

It is true that in many of the Northern institutions where etherization is by preference the practice, and in our own knowledge of the local effect of this medicant upon the genito-urinary tract—that is, its direct irritating influence—I say, it is strange that a more frequent sepsis of this sort is not pointed out. Of course, we all have ideas relative to the difference enjoyed in one institution by the immunity and in the other by the harmful effect. Whether it be due to the climatic difference or to the true difference in the effect of the drug upon the people living in a different latitude is a question left to the individual's decision. These cases I regard worthy of note and submit this upon the showing that in themselves they represent.

A Talk on X-Rays with Illustrations.

By N. F. THIBERGE, M. D., New Orleans.

In studying the literature on the X-Rays we are forced to draw two conclusions: That, though this field is occupied by fewer men, these men are meeting with more success in X-Ray work. This is especially apparent in skiagraphs of stone in the kidney. Williams (1) in his book, published in 1902, had collected only thirty-five successful skiagraphs since the discovery of X-Rays, while Guthrie (2), in January of 1904, estimated that the number had reached 200. Bevan (3) subsequently reported thirteen cases and claims that the X-rays make no error in lithiiasis. Shenton (4) reports twenty-eight cases, with ten failures. Fantino (5) reports two failures out of 120 cases. Armstrong (6) reports twenty-four out of twenty-eight. Leonard (7) sixty-five, with three failures. Ransohoff (8) advocates this procedure, so does Dunn (9). Boggs (10) reports two cases; three cases in Monell (11), and Cunningham's six out of seven make, after a hurried search in the literature, 395 successful skiagraphs in lithiiasis. I wish to add the following:

A. L., an engineer, 133 pounds, 5½ feet, gives a typical history of persistent soreness in the right lumbar region, hematuria, pyuria and twelve typical attacks of renal colic covering a period of two and one-half years.

Under fluoroscopic examination a transient very faint shadow was seen at the "Bevan" point. This skiagraph was taken at night after a course of quinine, as recommended by Morton (23), with a medium Wolfe tube without intensifying screen; exposure ten minutes at eighteen inches. The negative which accompanies it, being thin, can easily be examined in this frame, which has a white paper behind it, by viewing it twenty feet away. The method is a modification of Stover's (13), but made independent of his. This stone, weighing 11½ grains, of uric acid, was removed by Dr. Bloom from the pelvis of the kidneys. The patient is now convalescing. A skiagraph of the stone after removal is also submitted to your attention, together with that of a mulberry calculus weighing two ounces for comparison.

The weight of the successfully skiagraphed stones, where stated in reports, has been from eighteen grains to 275, with only one instance where it weighed ten grains (uric acid) and two (sand in pelvis) when it was less. Its composition was another difficulty. Williams claims it next to impossible, and I think all the operators think that it is quite difficult to X-Ray a uric acid stone.

Morris' (12) recommendation of cutting down into, to examine the kidney, and not to rely on the needle or palpation, was impressed on me at the operation, because it was only after a tedious search that the stone was located by palpation of the exposed kidney.

My therapeutic results practically correspond to those of Price (19), Coley (17), Pfahler (18), Ahrens (21), Brown and Jack (22), Stover (24), Childs (25), as the following report will show:

For epithelioma of the skin the result is ideal. Five cases are now clinically healed for a period of from two and a half years to one month without a recurrence so far; seven promise to be well shortly; one, an extension one of the forearm, died in the third month of treatment; another, a fourth recurrence, is slightly better, and only one so far, a recurrence after two operations, has increased.

I regret to say that epithelioma on mucous surfaces is not so easily influenced. A case under vigorous treatment, after responding quickly with a decided improvement, became worse.

An inoperable carcinoma of the cervix in which Dr. Gabert gave me valuable assistance, ran an interesting course: uterus became more movable, discharge, hemorrhages, general health—all improved under three months of X-Rays. She died one year after with marked cachexia. This result is identical to Tousey's case (15) of March 11, 1905 (*Journal A. M. A.*)

Of especial interest to me have been the results attained in recurring malignant growths of the breast. In those cases where treatment has been instituted directly after excision all attempts at recurrence were held in check by the rays, but a reapppearance in the other breast or signs of mediastinal or pleural involvement were noticed, forcing me to conclude that the ideal treatment (which I am now attempting) in these cases is: Never let the rays take the place of a radical operation, but excise as early as possible, a few days after which ray the wound, the other breast, the mediastinum and the axillary and clavicular glands, giving quinin internally to increase the efficacy of the rays. For edema of the arm I use high frequency current in connection with the rays with good result. Lee's (16) conclusions, however, are that X-rays do not check or prevent metastasis.

An osteosarcoma of the sternum after two months' treatment was apparently healed, but the patient discontinued treatment and I have been unable to follow the case.

For two lupus cases I am able to report improvement; one is under treatment now, with a promise of gradual cure, while another of seven years' standing, after three months' steady improvement, became stationary for two months, after which applications were discontinued.

The following ailments were benefited very much by X-rays: Tubercular glands, tuber peritonitis, general tuberculosis, phthisis, scars following operations and burns, pain of cancer and of chronic ostitis, neuralgias, chronic colitis, urethral polypus, while sarcoma of the parotid and of the pharynx both advanced; senile gangrene and eczema have resisted its effects.

Hodgkins' disease of four years' duration after a quick improvement was followed by death.

A case of extensive psoriasis was clinically healed with eight or ten applications.

A persistent sinus, following Edebohl's operation, has been cured by seven applications since one year.

After three years' work in the Hotel Dieu laboratory I have come to the following conclusions:

(1) The rays seem to have a special stimulating effect on nutrition in both extremes, by absorption of malignant growth (a product in my mind of hypernutrition) and a substitution of low grade tissue, like scar tissue, by normal tissue (correcting a product of undue nutrition).

(2) The rays possess a selective action on lymphatic tissue.

(3) Sarcoma shows rather a greater resistance to X-rays than carcinoma. Is this due to the fact that sarcoma is more independent of the lymphatic system than carcinoma?

(4) I think the diagnostic value of the X-rays, even in minute changes, has been established, and that the future to the operation in the therapeutic field is very encouraging; that with more accurate apparatus and a more thorough study of the composition of the "X-ray spectrum" we will succeed to convert the transient

but marked initial improvement, noticed in malignant diseases of the breast, into a permanent cure. I consider it a duty for us to make some more effort for these poor patients. We know that an alarming percentage of these growths recur after excision, and that when they do recur it means death, and that shortly. The only hope offered them is the X-rays. Should we not endeavor to perfect this agent? Surely, any advance, however small, will amply reward our effort.

(3) Bevan. Chicago *U. of M. Society X-Rays.*
(12) Stover. *Journ. A. M. A.,* April 1, 1905.
(14) *Lancet,* 1147, Vol. 1, 1903.
(4) Shenton. *Ibid.*
(5) Fantino. *Journ. A. M. A.,* 1904.
(6) Armstrong. *Montreal Med. J.,* p. 552, July, 1903.
(7) Leonard. *Med. News,* Feb. 15, 1902.
(13) Lucas, Nov., 1904. *Archive Electrology and Radiology.*
(8) Ransohoff. *Med.,* 1904, p. 1011, Nov. 26.
(9) Dunn. *St. Paul Med. J.,* Vol. 5, Dec., 1903.
(10) Boggs. *N. Y. Med. Journ.,* April 30, 1904, p. 817.
(2) Guthrie, Jan., 1904. *N. O. MED. & S. J.*
(11) Monelle's Electro-Therapeutics.
(1) Williams' Electro-Therapeutics.
(12) Morris' Surgery of Kidney, Vol. 2, p. 186.
(15) Tousey. *N. Y. Med. J.,* March 11, 1905.
(16) Lee. *Brooklyn Med. J.,* 1905, April.
(17) Colry. *Med. News,* Feb. 6, 1904.
(18) Pfahlin. *Journ. A. M. A.,* Aug. 6, 1904.
(19) Price, *Ibid.*
(20) Green. *Dublin Med. J.,* Oct. 1, 1904.
(21) Ahrens. *Journ. A. M. A.,* Aug. 6, 1904.
(22) Brown and Jack, *Ibid.*
(24) Storn. *Denver Med. Times,* April, 1904.
(25) Childs' *N. Y. Med. J.,* July 2, 1904.
(26) Vose & Howe, *J. Med. Research,* Boston, Jan., 1905.

DISCUSSION OF DR. THIBERGE'S PAPER ON X-RAYS.

Dr. King. What apparatus do you use? Do you use coils or static machine?

Dr. Thiberge. I use coils, but do not like them very well.

Society Proceedings.

Orleans Parish Medical Society.

President, Dr. L. G. LeBeuf. *Secretary,* Dr. Allan Eustis.
141 Elk Place, New Orleans.

In Charge of the Publication Committee, Dr. Allan Eustis, Chairman,
Drs. Jules Lazard and H. Dupuy.

Meeting of August 26, 1905.

Dr. L. G. LeBeuf read a paper entitled

Some Notes on the History of Yellow Fever.

In an attempt to treat a subject of such magnitude, only a rapid superficial sketch can be given. The statistics and the enumeration of epidemics of the last three or four centuries certainly make very interesting reading matter, but it may be a little dry to you. [I want to save you from too much of this tabulation.] The references for these chronological and biographical tables I owe to Mr. George Augustin, our assistant secretary. They cover a list of journal articles and books from the earliest times from the XVI and the XVII centuries, to the last article on the sanitary condition in Havana by Dr. Taylor, in the *Journal of the American Medical Association,* July 8, 1905. When this table will be completed it will also have the number of cases at each visitation of the disease, the number of deaths and, as exactly as possible, a short sketch of the history of the principal epidemics. A good deal of that history, as we can readily understand, leads us to and prepares us for the conclusions arrived at recently at Camp Lazear, conclusions which meant the regeneration of Havana and Vera Cruz. We are, ourselves, it seems, to forge the last link in the chain of evidence which will forever take away the fear and panic of the yellow plague. We are furnishing the material for this as the holocaust on the altar of science. The laws of science, recognized and proven, were not followed, and we are now paying the penalty. Surely this sad experience will allow us to free ourselves from this chain, and our dear Southland, after this epidemic, will raise its head once more in the pride of its freedom. One can understand the importance of this review when we look back to what transpired in cities like Baltimore, Philadelphia and Boston, and understand the proofs which these experiences bring to our new creed on the transmission of yellow fever. These cities, struggling many years ago, as we are today, on the very verge of a great prosperity and splendid commercial development, were repeatedly held in check and well nigh blasted by the yellow fever scourge brought to them by the West Indian trade, but they were not discouraged and worked out their own regeneration. They did not know the mosquito theory, but, by a strange coincidence, they stumbled on the correction of the evil by trying to reach the same end which we are striving for at this moment, with our oil can, our 18-inch mesh wire screen and cheese cloth. They knew that they had to do something to improve their condition, and thought the foe was dirt and filth, and narrow, dark, crooked, over-crowded streets and improper water supply. They immediately devoted themselves to cleaning up and widening their streets, constructing parks, establishing running water and splendid drainage and sewerage systems. Unconsciously, they had destroyed the hosts of transmission without knowing in what way they had done so. By better hygiene, by having a water supply through a system of pipes, by draining swamps and stagnant water they had driven the stegomyia fasciata from its usual habitat. Reed and Carroll had been anticipated nearly one hundred years, and the history of these cities proves this great doctrine. Yellow fever is a tropical disease seen between North Latitude 38 or 38½ and down to South Latitude 36; it is found in nearly all portions of the low austral life zones. It is seen in Asia, on the coast and in the interior of India, in the Malay States, in the Celebes, New Guinea, in Japan and Palestine; in Australia, especially in Queensland, New South Wales, Victoria, and abundantly in South Australia; in Africa, on the West Coast from Senegambia to Nigeria, and on the East Coast from Port Said to Durban, in Pretoria, British Central Africa and Cape Town.

The first truly authentic history of an epidemic was in 1687, by Jean Terreyra de Rosa, at Olinda, Brazil. It lasted from 1687 to 1694, after the conquest of Pernambuco by the Portuguese Army. It was seen also in epidemic form at that time at the Barbadoes.

Ulloa, Cortez and many of the brave Spanish captains of these times came across the disease, and according to the description their historians give of the pest, which decimated their number, we recognize the *vomito prieto* of today. The traditions of the Aztecs, and their wall and rock paintings, show pictures of an avenging and chastising god driving the native Toltecs to the south. Very recently it was my privilege to visit the cellars and foundations of the Palace of Justice in Mexico City with my guide, Captain Porfirio Diaz, an able engineer, and son of President Diaz, who had built this place, and had unearthed various statues from a sacrificial temple there buried, among which was a dog, to this purpose, with its urn, in which the blood of the worshipper was allowed to flow.

The Aztecs called this disease Matlazahualt, and Humboldt tells us that it existed even as early as the eleventh century. In 1545, 1576, 1736, 1737, 1761 and 1777 it greatly decimated the native Mexican race in a number of places. Before the advent of the white colonists it was not general, as the natives traveled very little on account of the lack of roads and the high mountain ranges. They had no large vessels either to visit the West Indies, and did not have free communication. When the white colonists came they were more susceptible to the dangers of the disease, and as they were unacclimated were quickly the transmitting agent of it through all the low austral regions. It was also more fatal to them than to the natives, and it retarded the settlement of many colonies on account of the panics it caused.

Prescott says: "It seems, in fact, that European civilization carries with it the germ of this poison. The moment a town is founded or a commercial center created it is certain to cause the explosion of the latent malignity of this poison in the air." We wonder today if our great historian had a forewarning of the mosquito when he made this practical application of the laws of today to the non-immune conquistadores of that time?

At Vera Cruz, in 1803, a noted observer, Col. de Constango, a colonel in the engineer service, noted first, most carefully, that, though the most severe heat in Vera Cruz was in May, the *vomito* was seen in greatest amount in the month of September and the month of October, about the time of the heaviest rains. The rain-fall during those two months is nearly as great as during the entire year in London. He says that it is probably in the evaporation of the rainwater kept in containers that the real cause of the pest must be looked for. In Vera Cruz, when the northern winds (*los nortes*) begin early, the annual epidemic is much less. In the same latitude, in which most of the *vomito* is found, the observers of even that time noticed that, though they were in the same latitude and had the same temperature, the same amount of moisture, an infected case could be carried on the other side of a mountain range and non-immunes could nurse at the bedside of the patient without ever contracting yellow fever. This must have been on account of the lack of stegomyias.

The chronological table of dates and geographical locations of all the known visitations of yellow fever will show us the exact latitudinal limits of the spread of the disease. I will speak only of the principal epidemics of Europe and of this country; in the North, of New York, in Boston, in Baltimore, in Philadelphia, and in the South in Memphis, in Savannah, and our own experiences in New Orleans.

In Europe. In 1800, yellow fever worked great havoc in Spain. In nine cities in Andalusia, with a population of 279,560, there were 79,500 deaths, an average of 30% of the population.

At Cadiz, population, 57,600, there were 48,688 cases and 16,000 deaths. At Seville, population 80,000, there were 61,718 cases and 30,000 deaths. At Xeres, population 30,000, nearly half the popution (12,000) died.

In Barcelona, in 1870, there were 1,000 cases and 360 deaths brought by infection from the ship "Maria."

In London, in 1660, population 500,000, there were 97,000 deaths.

In Constantinople, in 1812, the mortality was nearly 160,000.

In America. New York. Cases in 1789, 1791, 1795, 1800, 1803, 1804, 1805, 1819, 1820, 1822; epidemic in 1820 and 1870.

Boston. In 1798 there appeared the first epidemic of yellow fever; also, in 1819 and 1870.

Baltimore. In 1819 there were 2,200 cases of fever, of which 300 died. The fever continued in 1820 and also in 1821. General removal was practiced for the first time in a roped off district. In 1822 a fact of great interest was noted in the epidemic, as a proof of the modern creed of today. The fever was on Commerce street, which runs north and south from the docks and wharves to Exchange place. At the junction of these streets stood a large building fronting Exchange place, but with entrance also on Commerce street. From the rear of both ends of this building another building extended back fifty feet and these buildings were divided by a wall fifteen or twenty feet high. A good deal of business was transacted with the docks and wharves on the side which had an entrance on Commerce street and five cases of yellow fever took place there, all white. None of the people on the other side took the fever, though there were a number of families of non-immunes there. On the side on which the fever spread the roof of a shed acted as a receptacle for rain water, and Dr. H. J Jameson, who made the observations, attributed the fever there to the poisonous effluvia which arose from this water. In the epidemic of Baltimore in 1876, Dr. R. D. Murray, in his report to the Supervising Surgeon General, says: "The same filth accumulations, the same want of drainage, the same character of houses and surroundings, obtained there as in Key West in 1875." The seat of the outbreak in Baltimore in 1878 was in a small peninsula bounded on three sides by water, where 200 or 300 people lived. The infection was traceable to an infected ship. First case was on the 14th of September, forty-four cases following, out of which forty died. The authorities immediately removed about 150 persons of that place to the Quarantine Hospital, some miles away. A cordon was placed around the locality and the whole place purified, hundreds of cartloads of filth removed, privies were emptied and filled up with clay and the houses and furniture were disinfected. Not a single case showed itself again after this and the trouble disappeared as if by magic. At the segregation camp, where 150 persons were removed and corralled, only twenty-nine were treated for the fever and fifteen died; none else had it. Only one refugee, who had attempted to escape, died at the Detention Hospital. From 1855 this same peninsula had frequently been visited by sporadic cases of fever, but since this sanitary treatment no return of yellow fever was ever seen there.

Philadelphia. In 1699, seventeen years after the foundation of the town, from imperfect records given in letters of a medical man of that time, when the population was 4,000, the mortality from yellow fever was 200. Complete exemption existed for forty-two years, when the second epidemic appeared (1741), with 240 deaths. No cause was found for either visitation of the disease. In 1744 some fever cases were seen and for the first time it was traceable to the arrival of a vessel coming from the West Indies.

In 1760 some few cases.

In 1762 several hundred died. The disease was again traceable to the quarters of sailors recently arrived from Havana. Thirty-one years elapsed without the appearance of the disease.

In 1793 the city had the worst epidemic of all. Out of a population of 50,000 the mortality was 4,000, 12,000 having sought refuge in the country, reducing the population to 38,000, making a death rate of 1 to 9. There was an average of fifty-two deaths a day for eleven weeks. The fever was so great that the people locked themselves in their houses, men and women smoked tobacco continuously, burned it in the houses and streets, and fumes of camphor and vinegar and tar were inhaled. Tarred ropes were carried around the neck and secreted about the clothing. Men chewed garlic, walked in the middle of the street. When they met anyone on the street they chose the windward side of the passer-by and committed many other ridiculous acts. In this epidemic the infection was clearly proven to have been carried by a ship from the West Indies.

In 1794, 1795 and 1796 there were a few cases.

In 1797 another epidemic broke out. One-half the population refugeed, 1,300 died.

In 1798 there was again a general exodus, two-fifths of the population fleeing. Of the 20,000 who remained the Board of Health reports 4,868 cases, one-quarter of the remaining population, of which 3,600 died, an average of over 80 per cent. mortality.

In 1799 there was again a general exodus; 1,000 died.

In 1800-01, about 20 deaths.

In 1802, 835 died.

In 1803, 190 died.

In 1805, 400 died.

In 1806, 1807, 1808, 1809, 1811, only a few cases.

In 1819, 24 cases; 20 died.

In 1820, 125 cases; 83 died.

In 1826, 2 cases.

In 1841, 1 case, which was slipped through quarantine. Twenty-seven years then elapsed without any more cases. In 1853 the Cuban ship "Mandarin" brought the disease again to Philadelphia. There were 170 cases and 122 deaths.

In 1854 the Pennsylvania Hospital had 24 cases; 6 died.

In 1855, 6 cases and 6 deaths.

In 1856, 4 cases and 4 deaths.

In 1857, 1 case and 1 death.

In 1858, 1 case and 1 death.

In 1859, 4 cases and 3 deaths.

In 1869, 1 case and 1 death.

In 1870, 1 case and 1 death.

In 1870 the brig "Thome" arrived at the Lazaretto with a cargo of logwood and reeking with filth. The captain had died from yellow fever on the journey. The stevedores unloading the ship and the bargemen and employees and officers of the Lazaretto contracted the disease. Twenty-nine were taken sick and eighteen died. In September of that year the "Waterwitch," from Cienfuegos, Cuba, had five cases, of which one died.

Since 1870 about twenty-five or thirty cases entered Philadelphia, but there has not been anything of an epidemic to this day.

After giving a short sketch of the behavior of the disease in the principal towns which have been afflicted in Europe and in the Northern States, I want to speak of the experiences of a few Southern places, concluding with New Orleans.

In the South, together with slavery, this scourge has been the avenging Nemesis, paralyzing all our efforts, neutralizing our progress and retarding our prosperity.

It is the hidden foe, the fear of the unknown pest, which carries terror in the heart; no barriers, no precautions, no amount of disinfection, even the most careful segregation, can check it. All measures had been used, sane or even insane measures, but without success. If we condemn the panics and the shotgun quarantines of former days, we must remember that we are now in 1905 and that the American Commission has already published its labors over four years ago.

In Savannah. There was an epidemic in 1826. Out of a population of 3,000 there were 729 deaths, a death rate of 1 to 4.

In 1854, out of a population of 6,000, there were 1,040 deaths, a death rate of 1 to 6.

1876. Population, 20,561; deaths, 1,594, a death rate of 1 to 13.

Savannah has been immune from 1876, because: 1, all the lowtide lands were drained completely; 2, the western and eastern slopes, nearer still to the city, were drained also; 3, garbage and refuse have been carried away further than was done before; 4, the proper drainage of the lowlands around Savannah was enforced by legislative act; 5, the Bilbo Canal was deepened and flushed by high tides; 6, all swamps, ponds and privies were ordered drained and filled.

Savannah solved the mosquito theory by surrounding itself with a broad zone of dryness and perfect drainage, one mile wide.

In Memphis there were epidemics in 1853, 1855, 1874 (over 1,000 died) and in 1879.

In 1879 (July 9) the population was 38,400, and 24,800 were kept in the surrounding detention camps, the population being reduced by depopulation to 13,600, of which two-thirds were colored.

TABLE OF CASES.

	White.	Colored.	Total.
July	153	35	188
August	320	363	683
September	240	208	448
October	132	273	405
Total	845	879	1,724

TOTAL DEATHS.

	White.	Per Cent.	Colored.	Per Cent.	Total.
July	52	.339	5	.142	57
August	134	.419	43	.118	177
September	116	.483	43	.206	159
October	64	.490	15	.205	79
November	12	1.50	...	...	12
Total	378	4.44	106	.156	484

Total per cent., 31.

It is a question of history how Memphis has risen from this disaster and by an immense expenditure has succeeded ever since in avoiding the scourge.

Detention of a ship from an infected port is undoubtedly insufficient, as in the case of the ship "Golden Dream," on board of which yellow fever developed after a transit across the Atlantic to France.

In England and in Spain, after voyages which lasted from forty to fifty days, yellow fever developed in many instances.

The following are examples:

The brig "Alderman Pierre," from Cuba to Swansea, passage forty days, August, 1857.

Brig "Aimée Marie," from Cuba to St. Nazaire, France, forty-two days' passage, June, 1861.

Brig Mongosteen," from Cuba to Swansea, Wales, forty days' passage, 1864.

In none of these instances were there any cases of yellow fever reported on the logs of these ships; yet, within three or four days after their arrival, non-immunes visiting the ships on business or to unload them were taken sick. It would be interesting, in view of the corroboration we seem to have here of the presence of some sort of host in these cases, to learn whether the crews of these ships were all immune or not.

All this historical data is important now, as it confirms our latest beliefs, especially since we know of the interesting experiments made on the presence of the mosquitoes in the holds of sailing vessels and other ships. Our friend, Dr. Corput, so ably engaged in assisting Dr. White in his great work here, has found it even in the box contained under the grindstone in the forecastle.

Before I take up the last part of my subject, I want to give the best known instances where yellow fever was introduced by ships.

Omitting purposely the instance or instances which have caused our present trouble, as this will have to be established by another process and judgment than through the lines of a didactic paper, I wish to quickly enumerate the principal examples of this maritime mode of transmission.

In 1871, to New York, by steamer "Cleopatra."

In 1859, to New Orleans, by steamer from Key West.

In 1862 (July), to New Orleans, from Nassau.

In 1870, to New Orleans, by steamship "Agnes," from Honduras.

In 1871, to New Orleans, by brig "Mary Pratt," from Cuba.

In 1873, to New Orleans, by bark "Valparaiso," from Cuba.

In 1873, to Pensacola, by ship "Golden Dream," from Cuba (kept twenty-one days at quarantine).

In 1878, by the "Emily B. Sander," from Havana to New Orleans.

I could choose a score of most interesting relations of past visitations in our unfortunate Southland from my tabulation where this mode of conveyance was the beginning of large epidemics.

The results at Hampton, in 1899, where the United States Marine Hospital Service was given absolute militant power and eradicated the disease in three weeks, checking its inroad after the first fifty-seven cases. But if we give our sad experience here in New Orleans it will be enough, as it will be certain to cover all the known eras of a sad history.

In New Orleans. Yellow fever, since the foundation of the colony, has been the great enemy of Louisiana and of New Orleans. Sauvolle, the first Governor of Louisiana, living at Biloxi, died in 1701 of yellow fever. Iberville himself died in Havana of the same fever in 1706.

Governor Jacques Villeré, in 1820, was the first Governor of Louisiana who attempted to protect the people from the yearly visitations of the disease. He wrote a powerful message to the State Legislature recommending that some restrictions be placed against the West Indian trade. He announced the fact, since then well proven, that yellow fever was not endemic here, but was always brought from outside. He showed, as a proof of this, that in the Parish Prison that the inmates kept in closed cells were never infected.

We find reference of yellow fever having been imported here from the very foundation of the city (1717), still we have no accurate knowledge of its presence before 1796. It seems improbable that its absence could be true, considering the trade we had with the West Indies during that interval of seventy-five years.

A peculiar fact which I would like to emphasize, as I have never seen it mentioned before, has come to my knowledge in reading the "History of Louisiana," by Charles Gayarré and Prof. Alcée Fortier, together with family documents which I have. Most of the sailing vessels which came over from Europe for our sugar and molasses came over with a partial load to the West Indies—to Martinique, Guadaloupe, Cuba, Jamaica, Hayti and other islands. When they had unloaded part of this cargo they were invariably ballasted with stones, round cobblestones, of which most of our old pavements are made. These were placed in the holds of these sailing vessels and by their weight undoubtedly increased the accumulation of bilge and seepage water. Looking over the records of the Department of Street Improvements I find, through an imperfect record, that the practice of unloading this ballast with all its bilge water was started about 1817 or 1820 and that it was eagerly sought by the city authorities, but I have no doubt that the laborers at work in the holds of these ships, in those dark, mosquito-breeding holds, were very often inoculated. The wealthy sugar planters in the country felt absolutely safe from any danger of infection, and if any friend or relative came to them as a refugee and became sick they housed the cases, and there was never any instance of their contracting the disease. It did not seem to spread in the country until the epidemic of 1853. Some few years previous to that a prominent planter, in building a magnificent garden, known throughout the State, began hauling, by luggers, the same kind of ballast stones from ships in New Orleans to his plantation. He began this in 1844 and many of his neighbors kept up the practice until 1853, when the epidemic in New Orleans seems to have spread that year for the first time all over the plantations and especially amongst the families of the planters themselves. The very first victim was the only son of this planter, and many hundreds of the people died afterwards, and yellow fever has been present ever since all along our rich alluvial coast.

Our records are not accurate during the period of time between 1796 and 1817, but we had a few cases almost every year. It is only from 1817 that the statistics are found correctly kept.

DEATHS FROM YELLOW FEVER IN NEW ORLEANS FROM 1817 TO 1904.

1817		800
1818		115
1819		425
1820		400
1821		...
1822		808
1823		...
1824		108
1825		49
1826		5
1827		109
1828		130
1829		900
1830		117
1831		2
1832		400
1833		1,000
1834		95
1835		...
1836		5
1837		1,300
1838		...
1839		800
1840		3
1841		1,800
1842		211
1843		692
1844		148
1845		2
1846		160
1847		2,600
1848		872
1849		769
1850		107
1851		17
1852		456
1853		7,849
1854		2,316
1855		2,615
1856		74
1857		200
1858		4,855
1859		92
1860		15
1861		...
1862		2
1863		2
1864		6
1865		1
1866		185
1867		3,107
1868		3
1869		3
1870		587
1871		54
1872		39
1875		61
1876		42
1877		1
1878	Cases 14,916	4,056
1879	Cases 48	19
1880		...
1881		...

The worst were in 1833, 1837, 1841, 1847, 1853, 1854, 1855 and 1867.

1882		...
1883		...
1884		...
1884		...
1885		...
1886		...
1887		...
1888		...
1889		...
1890		...
1891		...
1892		...
1893		...
1893		...
1894		...
1895		...
1896		...
1897	Cases 1,827	298
1898	Cases 118	57
1899	Cases 81	23
1900		...
1901		...
1902		...
1903		...
1904		...
1905		...

The heaviest mortality was during the series of years 1853, 1854 and 1855, during which period the total mortality in our city was 37,026, of which 12,780 had been caused by yellow fever.

A notable fact occurred during the fatal epidemic of 1858. The first case was undoubtedly transmitted to a ship lying in the immediate proximity of the "Elizabeth Ellen," which was itself an infected ship from St. Thomas.

In 1859, not traceable outside.

In 1860, not traceable outside.

From 1862 to 1867 the Board of Health could not trace it.

In 1869 it was traced to the "Belgravia," from Liverpool.

In 1870 to the "Agnes," from Honduras.

But it was not clearly established to have originated wholly from the "Agnes."

In 1873, traced to bark "Valparaiso," from Havana.

In 1874, not traced to foreign importation.

In 1875, not traced to foreign importation.

In 1876, not traced to foreign importation.

The origin of the terrible epidemic of 1878 was through a steamship, the "Emily B. Sander," from Havana. It reached Quarantine on May 22, 1878, and was detained only six hours. Clark, the purser, was sick when he reached the station, but he passed through, stating that he had neuralgia. Taken in a cab to a residence, he died on May 25 in convulsions, undoubtedly uremic. Tom Elliott, also taken sick on May 24, died within five days. The diagnosis of malaria was made in both cases by two of the most competent physicians of the city. After the death of the second case the President of the Board of Health declared it to be yellow fever and an autopsy proved this on the 29th of May.

About the same time another ship, the "Borussia," left Panama on May 18, arriving at the Quarantine Station on May 21 with five cases of yellow fever. Passengers and crew amounted to ninety. This vessel was kept eleven and one-half days there, during which it was fumigated daily for four hours with sulphur. All her passengers were watched closely; none developed the fever. Many infected ships came through at this time, which, after detention and proper treatment with sulphur, showed no further spread of disease.

This epidemic had the following cases and deaths:

EPIDEMIC IN 1878.

July.	New Cases.	Total.	Deaths.	Total.
21	..	..	..	7
22	..	..	1	8
23	..	10	2	10
24	2	21	1	11
25	2	23	2	13
26	13	36	5	18
27	18	54	3	21
28	5	59	7	28
29	21	80	5	33
30	24	104	1	34
31	31	135	5	39
August.				
1	24	159	7	46
2	36	195	7	56
3	38	233	7	60
4	20	253	11	71
5	28	281	12	83
6	35	316	5	88
7	37	353	7	85
8	34	387	11	106
9	44	431	12	118
10	35	466	8	126
11	22	488	14	140
12	31	519	12	152
13	43	562	21	173
14	134	696	20	193
15	98	794	17	210
16	108	902	29	239
17	73	975	27	266
18	115	1,090	47	313
19	129	1,219	42	335
20	136	1,355	41	496
21	107	1,462	40	436
22	88	1,550	58	494
23	123	1,673	40	534
24	193	1,866	42	576
25	163	2,089	33	609
26	225	2,154	44	653
27	194	2,948	49	704
28	220	2,568	57	759
29	140	2,708	49	808
30	169	2,877	59	867
31	234	3,111	48	915
September.				
1	260	3,371	88	1,008
2	229	3,570	88	1,091
3	327	3,907	83	1,174
4	212	4,159	72	1,246
5	201	4,320	86	1,332
6	289	4,609	61	1,383

	New Cases.	Total.	Deaths.	Total.
7	232	4,841	77	1,470
8	226	5,067	81	1,551
9	144	5,211	87	1,638
10	230	5,441	80	1,718
11	253	5,694	90	1,808
12	212	5,909	57	1,865
13	238	6,137	58	1,923
14	309	6,446	59	1,982
15	149	6,596	59	2,041
16	108	6,703	73	2,114
17	223	6,926	62	2,176
18	252	7,178	68	2,244
19	195	7,373	55	2,299
20	165	7,383	69	2,368
21	105	7,643	62	2,439
22	195	7,838	40	2,470
23	134	7,972	44	2,514
24	139	8,111	58	2,572
25	100	8,211	36	2,608
26	129	8,340	44	2,652
27	122	8,462	51	2,703
28	159	8,462	55	2,758
29	264	8,621	52	2,819
30	100	8,885	35	2,845
October.				
1	231	9,216	54	2,896
2	186	9,402	56	2,952
3	111	9,513	51	3,003
4	305	9,818	54	3,057
5	283	10,303	52	3,112
6	125	10,485	59	3,171
7	84	10,600	41	3,212
8	149	10,786	49	3,261
9	143	10,929	42	3,303
10	113	11,042	48	3,451
11	164	11,206	49	3,400
12	203	11,409	50	3,440
13	128	11,537	50	3,490
14	183	11,720	29	3,519
15	135	11,833	30	3,548
16	110	11,965	28	3,557
17	128	11,093	24	3,599
18	89	12,182	36	3,536
19	55	12,237	25	3,660
20	44	12,281	29	3,698
21	31	13,312	44	3,733
22	114	12,426	42	3,775
23	172	12,599	19	3,794
24	69	12,668	16	3,810
25	124	12,729	18	3,828
26	63	12,885	31	3,849
27	74	12,929	22	3,871
28	21	12,950	23	3,894
29	52	13,002	10	3,903
30	34	13,036	13	3,917
31	47	13,038	12	3,939

November.

	New Cases.	Total.	Deaths.	Total.
1	80	13,162	8	3,939
2	3	13,166	8	3,945
3	47	13,212	9	3,954
4	51	13,224	4	3,958
5	52	13,206	9	3,969
6	21	13,317	5	3,972
7	..	13,317	3	3,975
8	..	13,317	2	3,977
9	..	13,317	4	3,981
10	..	13,317	1	3,982
11	..	13,317	..	3,982
12	..	13,317	2	3,984
13	..	13,317	..	3,984
14	..	13,317	4	3,984

EPIDEMIC IN 1897.

September.	Cases.	Deaths.
16	20	1
17	9	1
18	5	1
19	6	3
20	18	..
21	9	..
22	12	2
23	9	3
24	10	4
25	23	2
26	17	..
27	22	2
28	19	2
29	25	4
30	24	3
October.		
1	30	2
2	28	4
3	31	2
4	28	9
5	34	2
6	46	5
7	31	2
8	49	5
9	35	6
10	37	5
11	39	4
12	38	3
13	31	9
14	41	4
15	48	3
16	30	4
17	24	5
18	37	7
19	56	4
20	60	6

	Cases.	Deaths.
21	43	2
22	50	5
23	49	7
24	31	3
25	57	11
26	58	7
27	52	11
28	65	8
29	54	5
30	35	9
31	32	5
November.		
1	38	12
2	35	6
3	52	5
4	40	7
5	31	10
6	23	5
7	13	8
8	14	7
9	8	4
10	7	4
11	12	6
12	7	2
13	11	2
14	9	3
15	11	2
16	11	2
17	7	3
18	6	2
19	6	..
20	10	4
21	8	3
22	6	1
	1,875	281

EPIDEMIC IN 1905.

July.	New Cases.	Total.	Deaths.	Total.
24	150	150	27	27
25	7	157	4	31
26	12	169	6	37
27	26	195	2	39
28	21	216	3	42
29	29	245	7	49
30	27	272	3	52
31	21	293	5	57
August.				
1	42	335	6	63
2	32	367	11	74
3	54	421	5	79
4	43	464	5	84

	New Cases.	Total.	Deaths.	Total.
5	30	494	8	92
6	30	524	8	100
7	32	556	8	108
8	60	616	4	112
9	63	679	7	119
10	68	747	5	124
11	61	808	9	133
12	105	913	9	142

In 1879 the first case which took place in New Orleans was in the family of Mr. Stout. They had refugeed during the epidemic of 1878 and remained at Mississippi City until December, when they returned to town and occupied a house which had had five cases and one death in 1878. On June 16 a child took sick with the fever and all the members of the family became ill following this.

That year there were three deaths in July and one in August, while the surrounding country was widely infected. We had an interregnum of nineteen years free of fever, due in great part to the consistent and almost perfect quarantine established by Dr. Jos. Holt. Early in 1897 an epidemic of a peculiarly light type, with decided hybrid characteristics of both dengue and malarial fever, appeared at Ocean Springs, Miss. It spread for about three weeks pretty generally, several hundred being affected before the health authorities of Louisiana and Mississippi examined into it. When they did, though, they pronounced it dengue. Later, a number of deaths occurring, another investigation was made with a post-mortem, and then it was declared to be yellow fever. Quarantine was then established, but it was already too late, and a perfect exodus had taken place, scattering the infection in numerous foci all through New Orleans, Mobile and other places.

The first case of yellow fever officially announced was on September 17, 1897. This case was diagnosed by an expert representing the State Board of Health and was telegraphed by *Dr. Souchon to the authorities of the neighboring States and to the United States Marine Hospital Service. New Orleans was quarantined on all sides. Cases were reported up to October 22, when an early frost occurred. Type of disease was very mild.

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*Dr. Olliphant is evidently meant by the author.—Eds.

1899.

First case reported May 28; died.

Second case, August 28; died.

Third case, September 1.

Fourth case, September 7.

From that date to November 15, seventy-seven additional cases were reported. The deaths were twenty-three.

A proper tabulation of this year's trouble, of 1898 and 1899 is herewith added. In completing this history, or better call it this imperfect analysis of yellow fever, I want to say that I will at a future time give also the entire relation of facts of the cause of this bitter experience.

Yellow Fever in New Orleans in 1878, 1879, 1897, 1898, 1899 and 1905.

(Compiled from Reports of Board of Health.)

	1878.		1879.		1897.		1898.		1899.		1905.	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Jan							First Case Sept. 17. Altogether 118.					
Feb												
March			1									
April			0									
May			0						1	1		
June			4									
July	135	26	12	3							293	57
August	2976	1025	13	4					80			
Sept	5909	1780	9	7	210	28		6		6		
Oct	5063	1065	9	5	1282	158		43		11		
Nov	734	147			335	105		7		5		
Dec	0	3			0	7						
Total	14916	4046	48	19	1827	298	118	57	81	23		

In conclusion, we find that in our city the mortuary statistics show a mortality since 1817 of 42,099 from this cause alone. Let us hope, like Havana, and like Mexico, that we will be able to close this record forever, and that, if this book is kept any longer, that, with the knowledge we have and the proofs of science within our reach, it will be a book of infamy to our health bodies and our duly constituted sanitarians.

Chronology.

AFRICA.

Boa Vista, on Board English ship "Eclair," 1845-6.
Cape Verde Islands, at the Ihla de Sal, 1873.
Island of Ascension, on board English ship "Bann," 1823.
Senegal, epidemic in 1778, 1878, 1881.
Sierra Leone, epidemic in the beginning of the century; also in 1884.

UNITED STATES.

Alabama.

General epidemic in 1847.
General epidemic in 1848.
General epidemic in 1853.
General epidemic in 1873.
Brewton, epidemic in 1883.
Mobile, epidemic in 1843, 1847, 1853, 1858.
Montgomery, epidemic in 1873.
Selma, epidemic in 1853, 1882.
Whiting, epidemic in 1870, 1873.

Arkansas.

Epidemic at Forrest City, 1879.
Epidemic at Grand Lake, 1853.

California.

Probably in 1883.

Connecticut.

Chatham, 1796.
Knowles Landing, 1822.
New Haven, 1794, 1849.
New London, epidemic in 1798.
Middleton, 1820.

Delaware.

Wilmington, 1798, 1800.

Florida.

General, 1887-88.
Fernandina, 1878.
Gainesville, 1888.
Jacksonville, 1888.
Key West, 1888.
Manatee, 1888.
Millview, 1883.
Palmetto, 1898.
Pensacola, 1867, 1873, 1882.

Georgia.

Atlanta, 1897.
Augusta, 1839, 1854.
Brunswick, 1893.
Saint Mary's, 1808 (violent epidemic).
Savannah, 1854, 1858, 1876, 1878.
Waynesboro, 1802.

Illinois.

Cairo, in the 80's; exact date not available.

Kentucky.

Bowling Green, 1878.
Cloverport, 1878.
Hickham, 1878.
Louisville, 1878.
Trenton, 1878.

Louisiana.

General, 1799, 1878, 1897.
New Orleans (supra).

Maryland.

Baltimore, 1794, 1800, 1819, 1876.

Massachusetts.

Boston, 1693, 1798, 1819, 1853.
Nantucket, Island of, 1763 and 1764.
Newburyport, 1796.
Sheffield, 1793, 1794, 1795.

Mississippi.

General epidemic, 1878.
Biloxi, 1702, 1886, 1887.
Cooper's Well, 1855.
East Pascagoula, 1875.
Monroe County, 1822.
Natchez, 1817-19-23-25-37-38-39-47-48-53.
Rodney, 1843, 1847.
Vicksburg, 1847, 1873, 1879.
Washington, 1825.

Missouri.

St. Louis, epidemic in 1878.

New Jersey.

Elizabeth, violent epidemic in 1798.
Port Amboy, 1812.

New York (State of).

Brooklyn, 1809.
Bellevue, 1803.
Catskill, 1803.
Governor's Island, 1870.
Long Island, 1858.
Staten Island, at Marine Hospital, 1821.
New York Bay, 1856.
New York City, 1745, 1789, 1791, violent epidemic in 1795, prevailed in 1798, 1800-03-05, 1819-22-70.

North Carolina.

Nebern, violent epidemic in 1864.
Wilmington, 1862.

Ohio.

General epidemic, 1878.
Gallipolis, violent, 1878.
Marietta, 1822 and 1823.

Pennsylvania.

Mifflin County, 1897-8-9.
Philadelphia, 1699, 1741, 1747, 1760, 1762, 1793, 4-5-6-7-8, 1800, 1-2-3-4-6-7-8-9-11; 1820-26-41-53-55-56-57-58-59-60; 1868-70-78, and in 1890 on board a Cuban ship.

Rhode Island.

Black's Island, 1801.
Providence, 1794, 1797, 1800, 1803, 1805, 1820.

South Carolina.

Charleston, epidemic in 1748, 1804, 1817, 1827, 1849, 1852, 1857, 1858.

Tennessee.

Bartlett, 1878.
Chattanooga, 1878.
Knoxville, 1858.
Memphis, 1853, 1855, 1873, 1878, 1879.
Nashville, 1878.

Texas.

General in 1873.
Brownsville, 1882.
Columbus, 1877.
Galveston, 1839, 1858, 1859, 1867, 1870, 1873, 1882, 1897.
Houston, 1847, 1867.
Marshall, 1873.
Navasota, 1867.

Virginia.

General epidemics, 1737, 1741, 1742.
Alexandria, 1803.
Hampton, 1899.
Norfolk, 1747, 1795, 1800, 1821, 1855.
Portsmouth, 1855.
Winchester, 1804.

EUROPE.

England.

Notherbank, 1866.
Southampton, 1852.
Swansea, 1865.

France.

Bordeaux, suspicious cases in 1875.
Marseilles, at Quarantine Station, 1821, 1870.
St. Nazaire, 1861.
Vendee, 1808.

Italy.

Leghorn, epidemic in 1804.
Venice, at Lazaretto, 1870.

Portugal.

Lisbon, violent epidemics in 1857 and 1861.

Spain.

Alicante, 1811.
Andalusia, general, 1800, 1804, 1820.
Balearic Islands, at Port Mahon, 1821.
Barcelona, 1803, 1821, 1870.
Cadiz, violent, 1800, 1804, 1820.
Carthagena, 1811, 1812.
Cordova, 1800, 1804.
Gibraltar, 1804, 1810, 1813, 1828.
Madrid, violent epidemic, 1878.
Malaga, 1803.

SOUTH AMERICA.

Guiana (British).

General in 1803, 1853, 1881.

Guiana (French).

General in 1885.

Argentine Republic.

Buenos Ayres, 1870.

Ecuador.

In the 90's.

Brazil.

General (violent), 1819.
Bahia, violent, 1849-50.
Rio de Janeiro, 1850, 1869, 1873, 1875, 1876.

Mexico.

General, 1852, 1853.
Vera Cruz, 1847, 1862, 1863, 1864, 1865, 1866, 1867, 1878, 1883, 1887.

Panama.

Prevails every year, but was violently epidemic in 1882 at Aspinwall and Colon.

WEST INDIES.

Antigua, 1816, 1835, 1839, 1842, 1853.
Barbadoes, 1770, 1771, 1816, 1817, 1849, 1881.
Bermuda, 1819, 1854, 1856, 1873.
Curacoa, on ship "Delaware," 1799.

CUBA.

Havana, 1794, and almost every year up to 1901.
Santiago, yearly visitations up to 1898.

Dominica, Island of, 1793-4-5-6; violent, 1838.
Granada, Island of, violent in 1793 and 1794.
Guadaloupe, 1816, 1825.
Hayti and **San Domingo**, 1896-7.
Jamaica, 1750, 1792, 1797, 1819, 1866.
Martinique, 1808, 1820-21-31-39-53-55-73.
Trinidad, 1817, 1853, 1869.

CANADA.

Halifax, 1862.
Quebec, 1805.

CENTRAL AMERICA.

Costa Rica.
Alajuela, 1899.
Herodia, 1899.
Punta Arenas, 1899.

And all coast towns almost annually.

DR. JUAN GUITERAS, Professor of Tropical Medicine at the University of Havana, a guest of the society, spoke on some

Personal Experiences in the Etiology and Treatment of Yellow Fever.

(*Abstract.*)

After thanking the members of the society for their courtesy in asking him to speak before them, he referred to the recent work of the South American Commission on Yellow Fever sent out by the Pasteur Institute. This commission claims that the offspring of an infected stegomyia is capable of transmitting the disease, having produced the disease in one instance by this means. Dr. Guiteras doubted the accuracy of this finding and stated that Drs. Marchoux and Simon, the members of this commission, did not lay great claim for the correctness of this finding, inasmuch as it was found in but one instance. Again, it was doubtful to Dr. Guiteras that the authorities in Havana could have eradicated the disease in that city as easily as was done had this been true. He then related some experiments along the same line that had been conducted by him at Las Animas Hospital. He had fed the progeny of infected mosquitoes on non-immunes in his laboratory for a long period of time, and, although many of them were the progeny of his most virulent mosquitoes, in no instance had a case of yellow fever resulted. He referred to the possible origin of an epidemic of yellow fever by infection from an unrecognized case of mild yellow fever, and he laid stress upon the fact that these mild cases, which occur especially in children, are often the source of a virulent infection. Prof. Chaillé, of this city, he stated, was the first to call attention, by statistics, to the fact that yellow fever is extremely mild, as a rule, in Cuba. Dr. Guiteras then referred to the so-called acclimatization fever of the Creole and stated that there was no doubt in his mind that this fever was simply a mild type of yellow fever, as pointed out by Blair, of British Guiana. It was wrong to think that the Creoles are natural immunes, but that they had mild attacks when very young. He stated, in this connection, that the reason that yellow fever did not spread in the Cuban quarter of Havana was because, after a mosquito bit a child suffering with yellow fever, there were no other non-immunes for the infected mosquito to bite.

The doctor considered that fumigation against the stegomyia was the most important point in an attempt to overcome an epidemic, but that this fumigation must be properly performed. He laid stress upon the necessity of sealing every crack and crevice in the room, and, if this were properly done, pyrethrum powder is as effective as sulphur, provided the room is swept after the mosquitoes are stunned. In Havana they had used nothing but pyrethrum.

Regarding the symptomatology of yellow fever he stated that he had found a great increase in the number of red cells in the peripheral circulation and also a great increase in the percentage of hemoglobin in the first three or four days. The per cent. reading on the Tolquist instrument, as a rule, was above 90, and, in some cases, he had observed it above 100%. He called attention to the fact that in malarial fever and typhoid fever the percentage of hemoglobin was low. He had not, as yet, obtained definite statistics on the percentage of hemoglobin in dengue fever. The diazo reaction of Erlich is absent in all uncomplicated yellow fever cases. Regarding the presence of albumen in the urine as a diagnostic point he called attention to the fact that it is very common in other fevers, but that in yellow fever as a rule the percentage of albumen was relatively greater.

A steady temperature of 103°, with no tendency to decline, indicates a very serious case of yellow fever, with probability of death, according to Dr. Guiteras, and he called attention to the fact that the period of remission in typical cases of yellow fever is often absent.

Speaking in support of the mosquito theory of the transmission of yellow fever he informed the members that in Havana yellow fever had every possible opportunity to spread by other ways than by the mosquito, which, as was well known, it had not done, and that the fight against the disease in that city had been solely against the mosquito. In Las Animas Hospital, which is thoroughly screened, they bring patients suffering with yellow fever and often keep them in the same room, in an adjoining bed, with non-immunes, but that they had never had a secondary case to develop. The bed in which the yellow fever patient may have died was never fumigated, excepting what it may have received by the burning of pyrethrum. Several of his attendants at the Las Animas Hospital are non-immunes, and, although they examine all secretions in his laboratory and collect samples of blood, they have never developed yellow fever.

DISCUSSION.

DR. CHASSAIGNAC, before discussing the subject, tendered the thanks of the society to Dr. Guiteras for his interesting talk, and, while not wishing to discuss Dr. Guiteras' remarks, he desired simply to add one point that Marchoux and Simon had brought up. These gentlemen, he stated, made a careful study of the habits of the stegomyia, and found that, while the stegomyia is a day mosquito, it bites during the day only when young. By the time they are twelve days old, which is the time necessary for them to become infective, they bite only at night, and this explains why there is greater danger of becoming infected at night time.

DR. MATAS, after thanking Dr. Guiteras, requested the doctor to outline his experiences at the bedside in the treatment of yellow fever.

DR. GUITERAS, in closing the discussion, said that during the epidemic of 1900 in Havana the routine treatment of these cases at

Las Animas Hospital was to give as little medicine as possible, no food, but plenty of liquid, both hot and cold, ice cap to the head, mustard plaster to the back and epigastrium, but nothing else of any consequence. In the other hospitals of Havana salol and other intestinal antiseptics were employed. As far as the efficiency of the treatment went the death rate of 18% at Las Animas Hospital certainly compared favorably with the high death rate of 22% in the other hospitals. A patient on admission to Las Animas Hospital is stripped and given a bath. The doctor believes that the death rate is lower and the disease is less severe when a patient is in a clean new room.

For the vomiting he uses five minims of the tincture of the chloride of iron, with lemon juice, which seems to alleviate the condition to a certain extent. For suppression of urine he employs three grains of calomel every three hours, but was unable to say that he had observed any great benefit from its use. He has used adrenalin for the hemorrhages, but without any effect.

PROF. RUPERT BOYCE, Dean of the Liverpool School of Tropical Medicine, a guest of the society, next spoke as follows:

(*Abstract.*)

Prof. Boyce referred to the fact that McCallum, of Baltimore, on November 13, 1897, reported having found peculiar bodies in the blood of crows, and on December 18, 1897, Ross first brought to the notice of the British practitioners that the malaria plasmodium enters the human blood through the anopheles. Previous to this Ross had submitted a paper claiming this fact, which had been rejected by all his colleagues, with the exception of Lord Lister. In 1899 Ross was elected lecturer of the Liverpool School of Tropical Medicine, being the first man to take a chair at this school. Prof. Boyce then spoke of the functions of the Liverpool School of Tropical Medicine, explaining that it was primarily established to distribute circulars and to send out research parties to study peculiar diseases of the tropics with which the English Government had to deal. Mr. Chamberlain had appreciated the importance of the school and its usefulness and as a result the Government had supported it actively. In all, some 7,000 medical men have been trained at this school for service in the tropical possessions of Great Britain. At one time special research work was not encouraged, the prime object being to distribute literature and knowledge on tropical diseases, as an evidence of which he mentioned that 10,000 copies of Ross' paper on the transmission of malaria had been distributed. At present, however, research work was greatly encouraged and there were working parties at present engaged in the Congo, in Uruguay and in other far-off places, studying the peculiar diseases of these regions. The doctor then referred to the discovery of the trypanosoma in the human body by Dutton. Before closing he spoke of the trials that would be encountered by the authorities in stamping out the present epidemic of yellow fever, as it would be difficult to persuade many inhabitants that the mosquito theory is the correct one. However, he was agreeably surprised and marveled at the work that had already been accomplished in the way of wholesale screening of cisterns and in general fumigation by the citizens of New Orleans.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

The Quarantine Conference.

When, at the initiative of the Governor of Tennessee, the Governors of the various Southern States joined in a call for a quarantine and immigration conference, it was feared by many that this convention would accomplish little owing to differences of opinion if not of interest and to criminations if not recriminations.

The result was agreeably surprising. Delegations came to Chattanooga from fourteen States; in fact, from all those most interested except Texas. While some debatable points were warmly discussed, the work of the conference was harmonious, carried on in a spirit of fairness, and resulted in the adoption with practical unanimity of resolutions upon the two subjects submitted to the assembly.

Louisiana contributed a large share of the ability, the earnestness and the enthusiasm which were brought forth on this occasion. Governor Blanchard made a logical and convincing as well as brilliant address on the subject of national control of quarantine. The entire delegation won the hearts of the conference by refusing to take advantage of their numbers in order to gain a preponderating influence and by voting to give each State represented the same number of votes. To the medical delegation from the State is due in great part the credit for the prominence given to anti-mosquito recommendations, as it was one of its members who introduced the only resolution on the subject. It was referred to the Committee on Quarantine and was embodied to a great extent in the resolutions which were finally presented to the conference and form the essence of the result it achieved as far as health matters are concerned.

The resolutions were submitted by Hon. John Sharp Williams, Chairman, and were as follows:

Whereas, The experience of recent years, and especially the experience of this year, have demonstrated beyond cavil that the house mosquito, known as the stegomyia fasciata, is the sole known cause of yellow fever epidemics, and have demonstrated the futility and nuisance of many antiquated methods of quarantine hitherto resorted to, and the wisdom and necessity, in the interest of public health and the public business, of uniform regulations to prevent the importation into the United States of yellow fever and its spread from State to State in the unfortunate event of its introduction; now, therefore,

Be it resolved, That we, delegates from Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, Maryland, North Carolina, South Carolina, Tennessee, Virginia and West Virginia, hereby respectfully request the Senate and House of Representatives, in Congress assembled, to enact a law whereby coast maritime and national frontier quarantine shall be placed exclusively under the control and jurisdiction of the United States Government, and that matters of interstate quarantine shall be placed under the control and jurisdiction of the United States Government, acting in co-operation with the several State Boards of Health.

We furthermore respectfully request that Congress shall make adequate appropriation to enforce and perfect the objects of this memorial and to stamp out as nearly as practicable the yellow-fever-carrying mosquito in its breeding or living places in the United States, and by negotiating arrangements with the governments of Central and South America and the West India Islands, in places where the said mosquito has its breeding places or exists in said countries.

Resolved, second, That we urge upon the Legislatures of the several Southern States that they enact quarantine regulations as nearly as possible in accord and conformity as hereafter enacted.

We furthermore urge the Governors of the said several States, with the above object in view specifically, to call the attention of the Legislatures of their respective States to the wisdom and policy of this course.

The entertainment consisted in a ride to Chickamauga Park, a drill and parade by the regiment of United States cavalry stationed at Fort Oglethorpe, near-by, luncheon in the mess room to the music of the cavalry band and served by some of the young troopers, with, finally, a drive back over Missionary Ridge, giving a complete view of the park, the beautiful surroundings and the industrial city of Chattanooga.

All the delegates seemed to enjoy themselves hugely after their two days of earnest and nearly continuous work and left impressed with Chattanooga's hospitality, as well as encouraged by the result obtained.

New Orleans Sewerage and the Water Supply.

The Sewerage and Water Board of New Orleans recently reported *in extenso* on the work being done in this city in providing the desiderata so long hoped for. An analysis of their report shows considerable progress and enough work already done to justify a reasonable hope for a successful issue in due time.

The separation of the drainage and sewerage systems, necessitated by topographic conditions, has compelled a much longer time in the completion of both, but in the end New Orleans will be the gainer by the delay.

The sewerage system as under way is made up of lines of pipes converging from the areas nearest the river to points in a curve laid along the inner crescent of the city, at which points pumping stations are established for the purpose of forcing the sewage into a final pumping station, which delivers the sewage into the river at a remote place.

At present 191.8 miles of sewers have been placed under contract, and of this 160.4 miles have been built and 118.3 miles have been inspected and approved. In the original plans about 400 miles are contemplated, leaving now 240 miles to be completed. It is stated that by June, 1906, it will be possible to have connections from houses to sewers started and at least a part of the system in operation. The remainder of the sewers are expected to be finished by the end of 1908.

The Board compliments itself and its operative forces on the results obtained and this encomium is shared in part by the daily press. Adverse criticism, however, has arisen because of the inactivity of the Board in the matter of a water supply. The *Daily States* rather sarcastically compares the usefulness of the sewerage system to the proverbial "bricks without straw."

Considerable speculation has been rife in the matter of a water supply for New Orleans and all sorts of suggestions have been made. The present supply as maintained by the New Orleans Water Works Company is absolutely inadequate in almost every particular. The water is drawn from the Mississippi and is distributed with its mud in evidence to householders and others who can or who are willing to pay the exorbitant rates charged for the supply. As a matter of convenience the idea of buying over this system and improving it subsequently has been very strongly urged. If the sewerage system is to be operative in 1906 such a plan must be considered seriously, for in six months it is quite unlikely that enough water supply can be realized to flush the sewers properly, and the sewers would be useless to many who are prevented by prohibitive charges from using the present water supply.

The evils of the cisterns for rain water have been highly emphasized during the past year, and their abolition must be an essential to a better sanitation, particularly in the matter of mosquitoes.

Altogether the outlook is good, and, as the people of New Orleans and the public press are constantly airing their criticisms, we feel that there can be no lagging. The era of prosperity for New Orleans has passed the dawn, and, with better times, there must come the better conditions, and we are optimistic enough to believe that both are to be fulfilled.

The Canal Zone Outlook.

The recent review of the status of the Canal Zone and the operations contemplated must carry considerable food for reflection and gratification to the sanitarians there and elsewhere. Chairman Shontz's latest official utterances flatly confess that the sanitation of the zone is the first essential to make the isthmus "fit to live in," and the proper food supply the next important consideration.

He gives a cursory mention to the workers in Panama, but when we consider how much has been already accomplished by Colonel Gorgas and Dr. Carter with their hard-working assistants every honor should attach to them.

A year ago most of the Canal Zone was fever ridden, Panama was periodically epidemic with yellow fever and beri beri, and now and then plague would develop; the streets were open sewers and the houses for the most part anything but habitable. Since that time a health department has been established, mosquito extermination has been undertaken and a sewerage and water system inaugurated, the latter practically put in operation. Two admirable hospitals at the terminal cities, Panama and Colon, have been put in thorough administrative shape, and, besides these, division hospitals have been established along the line of the railroad and canal.

Instead of uncertain habitations and questionable food the commission has gradually established stations for colonies of labor and strenuous efforts are being made to provide suitable food.

At first the sanitary needs of the canal proposition were not made as emphatic as they should have been and the political character of the early canal manipulation considerably discounted the efforts of the Sanitary Commission. Now the work is bearing fruit and the whole of the medical profession should feel a certain reasonable and just pride in our fellows who have isolated themselves in the midst of danger for the accomplishment of so much good.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of Dr. F. W. Parham, Assisted by Dr. F. Larue, New Orleans.

Stimulation Not Always the Best Treatment for Shock.—Dr. Morris Manges recently read a paper before the New York Polyclinic Medical Society which contained some suggestions that we consider of value in the treatment of shock. One is apt to think that when the signs of shock are present stimulation with whiskey, digitalis, camphor or other drugs known to have a stimulant effect are imperatively demanded, whereas the contrary is frequently true. They are not only not always demanded, but sometimes would be of positive harm. In considering stimulation the heart must be regarded as cnly a part of the whole circulatory apparatus and not the circulatory apparatus alone, but the entire individual must be taken into account; for instance, what is the use of stimulation when the primary fault is not due to circulation, but to insomnia, he asks? He recalled one patient, upon whom a colostomy had been performed, who was very ill and much depressed for no apparent reason. There was failing circulation. The patient had an idiosyncrasy for morphin, and bromides excited her. He ordered veronal, 20 grains, in hot saline solution, per enema, and in one-half hour the patient was quiet and the next morning improved. He was sure that if routine stimulation had been practiced it would have ended in death. What she needed was rest. This case illustrated what he had always claimed regarding stimulation. What was the use of whipping a tired horse with a heavy burden until he is relieved of part of his load? Stimulation should be resorted to after the burden of the overworked heart has been lessened by removing all possible causes of failing circulation.

Similar remark might be made with regard to the treatment of pneumonia, typhoid fever or cardiac affections. In these cases he thinks it would be a serious error to begin stimulation immediately. This should be resorted to only when needed.

In the case of shock a stimulant is not always the best thing to give. Morphin is one of the best things to use in many cases, and frequently has the happiest effect. This drug gives the heart and the whole body a chance to get its bearings, and then strychnin, or other direct stimulants, may be used in small doses with good effect, and muscles that may not respond to strychnin at first will sometimes respond promptly when it follows a dose of morphin. Should stimulation be clearly indicated, camphor is frequently the best stimulant to use, because it acts almost immediately. Strychnin requires a certain length of time and digitalis somewhat longer before it is absorbed.

In the discussion which followed the reading of this paper, stress was laid on the danger of over-stimulation in cases of heart failure from shock. One of the speakers called attention to the fact that the spinal centers in the shock were over stimulated, resulting in a spasm of the arterial system, including the heart, forcing the blood from the heart and arteries into the veins, which are relaxed and distended, owing to the paralysis of the sympathetic centres. One of the gentlemen discussing the paper said that the sheet anchor in shock is morphin. It is the routine order in the Polyclinic Hospital, in the speaker's (Dr. J. Riddle Goffe) service, to give to every patient subjected to operation, unless special instructions to the contrary have been given, ¼ grain of morphin hypodermically, as soon as the patient begins to recover from the anesthetic. This, in our opinion, is undoubtedly good practice, and is not only justifiable, but called for in all cases where there is profound shock and there is no absolute contra indication in the condition of the kidneys. We believe that stimulants are probably used to too great an extent after operative work, and take advantage of this opportunity to enjoin more care in meeting the indications in any particular case, not simply resorting to routine stimulation in every case.

As shown in the discussion above referred to, drugs like morphin that quiet irritation and relieve vascular spasm, are indicated sometimes, especially in the beginning of shock. The main thing to bear in mind is not to give a stimulant unless actually indicated, sometimes preferring the use of something which will allay irritation rather than to stimulate a nervous system and heart.

VAPOR METHOD OF ANESTHESIA.—Dr. James T. Gwathmey read a paper before the Medical Society of the County of New York, Sept. 25, on the "Vapor Method of Anesthesia." We find some notes on this paper in the *Medical Record*, and have also a personal communication from Dr. Gwathmey on the subject. We think it of sufficient interest to put before our readers. He called attention to the three most modern inhalers, namely, the Harcourt Chloroform Inhaler in England, the Braun Chloroform-Ether Inhaler in Germany and the Gigliementi Oxygen-Chloroform Inhaler in France, which represent the latest contributions towards the accurate administration of anesthetics. The objection to English and French inhalers is that they are for chloroform alone, and use closed masks with valves. The Braun Inhaler is the best, but mask is undesirable. The unique features of Dr. Gwathmey's inhaler are that chloroform or ether may be given singly or combined in any desired proportion; the ability to increase or decrease the air or oxygen without at the same time increasing or decreasing the anesthetic, and the mask is an anatomically correct fitting face piece, the rim of which is hollow and perforated around the inner margin to allow the vapor to escape, otherwise identical with the Esmarch mask. This is covered with four layers of gauze over which is placed a piece of oil silk or rubber tissue. A small opening is cut in the midle of this gauze so that during the induction period a few drops of chloroform may be added as in the case of vigorous alcoholics. Dr. Gwathmey's inhaler gives a maximum of 2 per cent. chloroform vapor with a minimum of 1/10 of 1 per cent. The inhaler consists of three ounce bottles, in each of which are four tubes varying in length, from one that reaches the bottom to one that penetrates only the stopper. These tubes represent four degrees of vapor strength, the longest with the mask just described has an estimated 1 per cent. vapor strength; the shortest, No. 1, representing a very attenuated vapor, 1/10 per cent. As the mask is not airtight, the vapor cannot be compressed, thus avoiding the danger of an over-dose. The advantages of this form of anesthesia are:

1st. A pleasant induction stage.

2d. Stage of excitement absent.

3d. Pulse and respiration normal. No mucous rale or billowy breathing.

4th. Complete relaxation.

5th. Absence of unpleasant after-effects on account of the attenuated vapor used.

6th. The continued use of an attenuated oxygen or air and chloroform vapor of known percentage, to which an attenuated ether vapor can be added, or substituted, when conditions require a change.

7th. A possible change in the vapor percentage with the same flow of oxygen or air, by a change of tubes or by varying the pressure in the same tube or by a combination of the two methods.

POPLITEAL ANEURISM; EXTIRPATION; GANGRENE OF THE LEG.—Mr. Faure (in *Revue de Chirurgie,* May 10, 1905) reported to the Société de Chirurgie the case of a newspaper distributor who had a large popliteal aneurism with only slight edema of the lower segment of the limb. Pulsation was perceptible in all the distal arteries, although quite feeble over the dorsalis pedis. The vessels were hard and tortuous. Mr. Faure, after applying the Esmarch bandage, began the extirpation. A vertical incision, in the long axis of the limb, exposed the nerves and vein. These, drawn aside, brought well to view the aneurismal tumor encroaching on the adductor foramen.

Two clamps were applied to artery, on proximal side of tumor, with an intervening cut.

The tumor, on removal from above downward, ruptured, and a large clot was freed. Extirpation was then facilitated. A clamp was placed at the distal end of the artery, which was severed lastly. After removing the Esmarch not a drop of blood was seen oozing from the wound. The clamps were replaced by catgut ligatures, and the wound was stitched. The following day the foot showed signs of gangrene rapidly involving the whole leg, necessitating a thigh amputation. This happened two weeks after the primary operation, the patient recovering after presenting a half inch slough of the flap.

On examining the specimen it was found to occupy the entire circumference of the artery; above, the anastamotica magna, and, below, the articular branches, as well as the bifurcation of the popliteal, had been respected, favoring thereby collateral circulation. If this did not occur, then the Esmarch band can be incriminated, which Mr. Faure will discard in similar cases with defective arterial system.

Mr. Guinard removed a huge aneurism involving the popliteal and femoral (Hunter's canal) from a patient with badly damaged arteries; no gangrene ensued. He accounts for this in that he always first ligates below the aneurism, thus avoiding the driving of clots from the sac into the peripheral arteries. He absolutely rejects the Esmarch band.

Mr. Tuffier extirpates aneurism like any other tumor, ligating as he proceeds. When feasible, he invariably first ligates the distal end so as to distend the sac and the peripheral vessels, facilitating their dissection. He never uses the Esmarch bandage.

Mr. Potherat said he did not minimize the importance of Mr. Guinard's remarks, but he is convinced that the arterial state of the patient is the essential factor.

Mr. Lucas-Championniere maintains that simple ligation causes less risk of gangrene than extirpation in cases of very large aneurisms.

Mr. Poirier likewise observed a case followed by gangrene of the leg after removal of a large popliteal aneurism. He had also first ligated the distal end. He asks if it would not be wiser in an arterio-sclerotic with a voluminous aneurism (popliteal) to first resort to simple ligation.

Mr. Quénu leans towards extirpation as less likely to cause gangrene than ligation.

COMMENT.—Here we observe a diversity of view expressed by well known surgeons of vast experience.

One of them thought simple ligation much less likely in large aneurisms to be followed by gangrene, while another held that the extirpation of the sac was distinctly safer. Most were agreed that the Esmarch bandage should be discarded, as adding to the danger of gangrene. Some were of opinion that the distal ligation should be done first to prevent the distribution of clots in the vessels of the leg below the aneurism, while one (Poirier) reported one case of extirpation of the sac where the distal ligation was first done, but was followed nevertheless by gangrene. He suggested that in arterio-sclerotic patients with voluminous aneurism (popliteal) simple ligation should first be resorted to.

It certainly strikes us as singular that no mention was made of the Matas operation, which, in our opinion, assures less risk of gangrene than any other expedient so far devised. Intra-aneurismal suture of the arterial openings *within the sac* approaches as near the ideal as we can hope to attain in the treatment of aneurisms to which it is applicable. It cuts out no blood current except that through the sac itself, and, instead of damaging the collateral circulation, actually favors it, both in the surrounding tissues and in the sac wall itself, because it takes off pressure from it by removing the contents of the sac.

Department of Obstetrics and Gynecology.

In Charge of DR. P. MICHINARD, Assisted by DR. C. J. MILLER, New Orleans

OPERATIVE TREATMENT OF PUERPERAL PYEMIA.—E. Bumm (*Berl. Klin. Woch.*) draws attention to the rapid spread of the poison from an infected endometrium by way of the veins that connect with the uterine circulatory system. The streptococci may be carried in various directions; virulent forms are soon carried by the blood current to the spermatic plexus, and hypogastric veins, then into the iliac veins, the femorals, and the vena cava. Such septic phlebitis with infected areas thrombosis give the picture of an acute pyemia. The chills begin in the end of the first or the beginning of the second week of the puerperal period. The phlebitic process may begin in the uterine wall and the broad ligaments, then extend to the peritoneum and give symptoms of simple pyemia. If the streptococci are only slightly virulent, the poison spreads more slowly; there is less tendency to pus formation, but inflammation occurs and there is phlegmasia alba dolens or phlebitis of pelvic veins. Again, there may be a chronic pyemia; a single center spreads the poison slowly, peripherally. The chills begin three or four weeks after labor, there are pauses of several days between them; the endometritis is cured and the thrombosis is the only cause of trouble. Acute pyemia usually ends in death. The slow form is also often fatal. Of 23 cases beginning in the first week, only four recovered, a mortality of 83 per cent. It is clear that local treatment of such an infection by intra-uterine douches cannot aid. The process has passed beyond the uterine walls. The same is true of inunctions of silver salve. Turpentine injections are of doubtful value. The author saved two out of four cases by surgical interference, removing the thrombosed veins and thus taking away the local cause of the spread of the poison. Of these he gives the histories. The diagnosis may often be made under ether after the first chills, when the good condition of the uterus can be demonstrated by normal exploration and the thrombus in the pelvic veins felt. Interference must be undertaken early before the spread of the streptococci from the original focus in the veins. Ligation and excision of the inflamed veins may be done either extraperitoneally through the abdominæ at the eleventh rib, extending the incision to the midle of Pourpart's ligament, or transperitoneally by way of the abdominal incision. The extra peritoneal method avoids the danger of infecting the peritoneum, but makes a very deep wound, and does not permit the following of the thrombotic process to its end. The transperitoneal may infect the peritoneum, but it gives a much better view of the pelvic contents. The spermatic veins are easily seen and the hypogastric and common iliac may be followed. For a chronic pyemia in which septic retentions from the wall of the vein are not to be feared, the transperitoneal method is to be preferred. Extirpation of the uterus is often unnecessary as that organ is not affected. —*Amer. Journ. of Obst.* (Oct.)

INDICATIONS FOR HYSTERECTOMY IN PUERPERAL SEPTICEMIA. —Dr. C. G. Cumston read a paper on this subject at the last meeting of the American Association of Obstetricians and Gynecologists.

He states that hysterectomy applied to the treatment of puerperal infection is as yet a mooted question, as far as its indications are concerned, and it would be quite illogical to advise this interference in all serious cases, as it would be systematically to condemn it. All surgeons seem to be in accord as to the great difficulty of formulating the indications for this operation, and especially the time when these become formal. To come to a conclusion, all clinical methods of examination and those of the laboratory must be employed. The latter, however, are far from being of equal value, as no positive result can be obtained from a bacteriological examination of the lochia or blood. Cytologic examination of the blood will give excellent data as far as the prognosis of the type of infection is concerned. Clinically, there is no one valuable sign, but, taken together, the symptoms obtained by careful intrauterine examination may indicate the necessity of surgical intervention when all other therapeutic measures have failed. Septicemia occurring at once after labor cannot derive benefit from surgery, but, on the other hand, it will appear that hysterectomy is indicated in cases of secondary septicemia with a slow evolution, or those taking on a pyemic type, proceeding by successive stages, on the condition that there are no visceral metastases, in which case surgical treatment would be a method of exception.—(Reports of *Amer. Med. Assoc. Journal.*)

SURGERY OF THE URETER.—At the Gynecological Congress in Kiel, June, 1905, Freund (*Zentral, für Gynakol,* 1905) recommended that, in cases of extensive resection of the ureter, the proximal end of the duct should be passed into the abdominal ostium of the Fallopian tube, the latter should then be divided at its uterine end, and straightway implanted into the bladder. The author says the fimbriæ of the tube form an excellent graft around the implanted portion of the ureter. The Fallopian tube is not severed from the mesosalpinx, and hence its blood supply is maintained. This method has been tested on animals by d'Urso and de Fabii, who had implanted the ureter into the uterine horn of bitches, and then after resection of the cornu from the uterus it was fixed in the top of the bladder. Ten days after this operation was performed the ureter on the opposite side was resected and implanted in the abdominal wound, or the kidney of this side resected. Experiments on the human cadaver show that the implantation of the ureter into the Fallopian tube is easily carried out. This plan of dealing with the ureter is not practicable in cases of abdominal hysterectomy for cancer, because the mesosalpinx is cut through at an early stage of the operation, and the broad ligament is finally all removed. It is indicated where resection has to be carried out in intra-ligamentary fibroids, or cystomata, or hydatids, which have pushed up the posterior layer of the broad ligament. In these cases the enucleation of the growths can be carried out without impairing the blood supply of the tube. In cases where the Fallopian tube cannot be used, the one ureter should be implanted into the other, as recommended by Kelly, MacMonagle and Sampson, and carried out by von Monaco, Casati and Boari on animals. The operation of implanting one ureter into another is carried out after the manner of an entero-anastomosis. Many animals have died from the results of defective technic, but these experiments are being continued.—*Jour. Obst. and Gyn. of the Brit. Emp.*

Department of General Medicine.

In Charge of Dr. E. M. Dupaquier, New Orleans.

Still a Question.—There can be little doubt that the principal and usual source from which the mosquito derives the malaria parasite is man. But to assert, as some have done, that man is the only source, is, I consider, going beyond evidence. If, in such a matter, analogy be accorded weight, the contrary might very well be the case. We know that the corresponding avian hæmamœbidæ, proteosoma and halteridium, each of them affects several bird-hosts. This fact might very well be held to indicate that the hæmamœbidæ of man have also a plurality of vertebrate hosts. It is true that, so far, attempts to transfer by transfusion of blood the human hæmamœbidæ to the lower animals have failed; but too much importance must not be accorded to this failure, seeing that the number of species experimented with has been limited. We know that similar parasites have been found in monkeys, dogs, sheep, horses and oxen, so that man is not the only mammal capable of harboring the genus. Dionisi's recent observations (1900-01) on the hæmamœbidæ of the bat are most suggestive. This observer has shown that, of three species of bats, each harbors a special species of parasite resembling one or other of the human hæmamœbidæ. This circumstance, especially if viewed in the light of the domestic habits of the bat, is most suggestive. On the assumption that man is the only intermediary of the parasites it is difficult to understand the insalubrity of many sparsely populated districts, and, also, the sudden explosion and rapid spread over large areas of malarial epidemics. These things are more comprehensible on the assumption that some other animal may share with man the privilege of being the intermediary of the malarial parasite. (Etiology, Prophylaxis and Treatment of Malaria, by Patrick Manson, M. D., etc. *The Practitioner.*)

Blackwater Fever.—The position that quinin is most commonly the cause of blackwater fever in those suffering with periodical attacks of malaria insufficiently treated, has, in spite of opposition, established itself, we believe, quite firmly. From time to time authors declare that they have found parasites in every case; but such statements cannot be received, as they are directly opposed to the experience of those who have examined cases with the greatest care, and found parasites only in a few. There are two points which require investigation: (1) Can quinin produce a diminution in the red cells without hemaglobinuria? (2) Is there any condition of the urine, *e. g.*, urobilinuria, albuminuria, "high color," etc., which will indicate when a person is on the verge of blackwater fever? The blood and urine need to be carefully analyzed in the pre-hemaglobinuric stage, so that the practitioner may have some guide as to when it is dangerous to administer quinin. The other determining causes of hemaglobinuria, *e. g.*, cold, severe physical exercise, etc., if these are really causes, require more precise definition.

Finally, we would draw attention to a point in the study of malaria in which progress is extremely slow. We know now some eighty anophelines. It is unsatisfactory that only in the case of eight or ten of these do we know with certainty that they convey malaria (*i. e.,* have sporozoits in their salivary glands). It is unscientific to adduce the existence of an anopheline in a locality as explaining the existence of malaria. We can only be certain of this when we have found that this anopheline actually does contain sporozoits.—*The Internat. Ann.,* 1905.—*Trop. Med.*

Miscellaneous.

Parisian Medical Gossip.

ANIMALS AND MUSIC—A DENTIST MONK—PREHISTORIC MEDICINE AND PREHISTORIC DENTISTS—INOCULATION IN THE EIGHTEENTH CENTURY—THE SOCIAL POSITION OF THE MODERN DOCTOR—MEDICINE AT BAGDAD.

(Translated by Dr. T. C. Minor, Cincinnati, Ohio.)

The *Gazette Medicale de Paris,* speaking of a volume lately issued by Breton, the painter, states the following *àpropos* to animals sensitive to colors and especially so as to music:

"Spiders quiver with joy in their webs at the sound of music. Indeed, almost all animal life is affected by harmonious strains. Most dogs show impatience, bark and even shed tears when music is heard. The most beautiful songs awake the loudest whinings. This leads one to curious reflections. Yet we cannot admit that the intensity of joy leads up to grief among animals as among human beings, but it would seem to raise the pathology of the dog to the mysteries of an impressionism, possible among a class of animals long thrown into contact with mankind. Parrots, too, for the same reason, often become intemperately esthetic and have even the reputation of often repeating music heard on a number of occasions. These capricious and knowing birds are ravished by musical notes. The author had a parrot, called 'Coco,' who adored the compositions of Haydn. At certain pieces he listened at first with head lowered; then, at the most pathetic passages, he raised himself on his perch, flapped his wings and flew into a passion. When sentimental strains were given he sighed like a lover full of tenderness. The playing over, he gave a significant murmur of thanks. When he went to bed he always said good night. He never talked except on days when we had music; the rest of the time he was sadly mute. All the world knows how the canary bird and other singing families of birds go wild on hearing music."

An Italian journal gives the following interesting item regarding Fra Orsenigo, a brother of the Order of St. John, who was the most popular tooth drawer in Rome. Fra, or Brother Orsenigo, died but recently, aged 67 years, of an obscure stomach disorder. He was a great eater and drinker. The news of his death created profound sorrow in "The Eternal City."

For many, many years he pulled the teeth of the poor of Rome. In his time it is safe to say he extirpated hundreds of pounds of teeth. He was a robust monk, with arms of steel. From 8 o'clock in the morning until early in the evening crowds of toothache sufferers might be seen—workingmen and workingwomen, boys and girls—waiting in line for Fra Orsenigo to pull their molars. Brother Orsenigo was broad shouldered and had a jolly face, an enormous hand and the grip of a prize fighter. His outfit consisted of a chair, a fountain of pure water and his mighty forceps. He never listened a moment for the lamentations of a patient. Throwing the head of the sufferer backward he held it in his giant grip, and, with his steel instrument once in the open mouth and on an offending fang, nothing withstood his rapid attack. When he pulled the tooth came out, sometimes a little maxillary bone, too, and pieces of gum in those tough subjects dentists often run across. The tooth pulled, the patient was bidden to wash his mouth out in the fountain and make way for the next sufferer. Fra Orsenigo was celebrated among the population. He was the terror of the children and the dread of old women. He never asked a fee for his services, but it was the custom of those who went to him to drop some small piece of money in an old trunk with a hole in its lid. He never took any antiseptic precautions and was never known to have had an accident in his immense practice. When patent dentists, protected by law, invaded Rome, Fra Orsenigo laughed them to scorn, and so great was his popularity that the law was never enforced in his case. He died in a sanitarium that he founded for the poor out of the receipts from his practice and economy.

According to a German journal Dr. Reiser, a dentist and paleontologist, has studied an immense number of skulls of the prehistoric period and made some very astonishing discoveries. He says:

"Among our ancestors of the stone and bronze periods caries of the teeth was very common. Moreover, the incisors were often found worn down to the roots; that shows that the man of the early epoch was a good chewer.

"The mouths of the subjects of these early dates were less better provided for than in these modern times. On certain of these teeth were found deposits of lime of a kind that leads us to believe that in the bronze age *there were dentists!*"

We fear we must contradict this able dental paleontologist. Our observations have been different.

First—*Dental caries was very rare among* prehistoric men. It only appears in the Roman period and is frequent only in the merovingian epoch.

As to the lime false dental work, observed by Reiser, we should like to see a single case.

True it is that the ancients used their teeth with vigor, often wearing them down to the very roots in mastication.

Certain inoculators who claim to direct contemporaneous medicine by the aid of the syringe, *a l'Institut Pasteur,* believe they are the originals. They have merely revived, for the syringe has simply replaced the lancet, and preventive vaccinations are only the substitutes for the inoculations that enjoyed so much fashion under Louis XV, the *well beloved.*

The *Gazette Medicale du Centre* has just found and published a very interesting letter, in which Lady Montague describes the variolic inoculation such as was practiced in 1718 in Adrianapolis, where she then resided.

ADRIANAPOLIS, April, 1718.

Madam A. G.—*Apropos* to diseases I wish to tell you something that would make you wish to be here. The dreadful smallpox, so widespread among us, is entirely inoffensive about this place, thanks to the invention of inoculation—the term used. There is a class of aged women, who perform this operation in the autumn, in the month of September, when the heat is over. They sent and asked families whether their members wished to prevent the taking of smallpox. The affair was treated as a pleasure party, and when fifteen to twenty persons were gathered the old woman, provided with a nutshell full of smallpox virus, chosen from a mild case, asked what vein it was desired to have opened. The one wished for puncture was indicated with a needle. It was painful—a simple scratch—the needle full of virus entering the vein at the point of puncture. After this a bandage was applied. Generally four or five veins were inoculated. The Greeks here, from superstition, are accustomed to puncture a vein in the middle of the forehead, one in each arm and another upon the breast, thus making the sign of the cross, that produces a bad facial expression if there be much ulceration. Some persons who inoculate on the legs and arms avoid such cicatrices, as the marks are hidden. The children and young inoculated play together for the remainder of the day and up to the eighth day enjoy seeming good health. Then a fever commences. They remain in bed two days, rarely three. They seldom have more than twenty to thirty pustules on the face and are never disfigured, so that when eight days pass they are as well as ever. At all the points of puncture there is a sore during the time of the fever. This sore is suppurating, and, no doubt, relieves the disease.

Thousands of people submit to the operation every year and our French Minister says: "They take the smallpox for amusement, as one takes to the mineral springs of Europe for pleasure." There are no examples, as far as I know, of persons dying, and I am convinced there is no harm in the operation and I intend trying it on my own child.

I have even patriotism enough to hope to establish this useful invention in England and shall not fail to write some of our doctors if I can find some of the English profession unselfish enough to sacrifice a considerable source of medical income for the good of all humanity. But the malady mentioned brings such large fees that resentment might be awakened in thus cutting off considerable of income. If I live I may have to make a war on them to introduce the invention. On that occasion you will admire my heroic heart. Your friend, etc., etc.

Dr. Lutaud, editor of the *Journal de Medécine de Paris,* recently remarked: "It is interesting to compare the social conditions of medical men in the different countries of the globe, and our investigations have led to the most agreeable of discovery, *i. e.,* that the situation of the French doctor socially is most to be envied."

The *British Medical Journal* undertook a vast inquiry into this subject. The June number of this English journal was almost entirely given up to this special inquiry.

The principal points of this investigation may be thus elaborated: Conditions of medical practice, rights and duties of practitioners towards the public and State; public medical services to the exclusion of the military ones; financial conditions of physicians according to various condition of population; medical profession and its relation to the laws; charlatanism and illegal practice; protection of professional interests; social and political position of doctors; finally, statistics of the profession with relation to the overcrowding of the profession. These statistics go to show that the financial condition of the profession is far from satisfactory. Naturally, the value for services rendered must be based on the cost of living in each country. In the majority of European lands professional incomes vary from 3,000 to 10,000 francs ($600 to $2,000).

Spain and Italy have the poorest paid medical men, the fees allowed by the public and Government are ridiculous and low. The medical profession in these two lands has few of its members in society, and but for a few who marry wealthy women there would be little social standing. In Italy, it is true, a small number have managed to elevate themselves. They have several Senators, the long-time Minister of Public Instruction being the most noted man in the medical profession.

At Berlin doctors do not enjoy much social or political prestige.

The majority of leading German physicians make only about 5,000 francs ($1,000) a year. Virchow was the only real luminous medical figure in Germany and stood even higher at times than Bismarck as a political leader. He was by all odds the grandest of later-day medical scientists.

In England physicians gain a fair living owing to the many positions in the colonial service, but English doctors enjoy but little political prestige. Jameson, Prime Minister of the Cape today and the original raider, is the leading medical politician in the English profession.

In the United States the position of the medical body in politics is badly defined. There are as many schools of medicine as creeds of religion, and it becomes difficult for a European doctor to exactly define the true value of an American physician's diploma. Except for official offices they hold but little prestige. Socially they only figure occasionally when wedded to wealthy women.

It is in France alone that the doctor in medicine holds many high political positions and enjoys much social life. Four of the Ministers of France are doctors, while the number of medical Senators, Representatives, Mayors and foreign officers is immense. In France the doctor in medicine is ever the leading politician. Who is better able and competent to hold offices than physicians? Doctors know the inner practices of life, the needs of all the classes of society and are best able to judge of all questions of social and moral life. The celebrated Laburthe, Minister of the Interior, is a physician. Few French doctors have large incomes, but they are the prime favorites of the people at all general elections.

In a dazzling and highly decorative style, with every sign of erudition and color, together with magnificent pen handling, *"Les Nuits de Bagdad"* (Paris, Ambert, 1905) is the new work of Giron and Albert Tozza, putting in every scene complete of the historical "Arabian Nights," in the days of the grand Khalif, Haroun al Raschid.

Readers who love mysterious dramas, especially those of harem life, will see unrolled in these marvelous pages the splendor of Oriental fetes, and need not complain of the recitals, resounding like fanfares, like great voices in the days of Charlemagne, while like a stream of life passing before our wondering eyes come the scenes of ancient Byzantine. The amateurs of medical curiosities will find ample food for thought and a legitimate satisfaction of their literary appetite in certain books of the *"Nuits de Bagdad."* There are chapter after chapter of learned medical footnotes. No one is ignorant of the fact that Mahometan countries have ever been the greatest admirers of doctors and medicines. The Arabian school, its doctrines and philosophy, find their full elucidation.

"Le ciel etait si doux et l'air si pur."

Those were the days of judiciary astrology, but from all times has not the medical corps been in love with the occult sciences, even that modern one, the microbian?

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,. Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

Minutes (*Continued from November Number*).

Afternoon Session, Friday, May 11, 1905.

Unfinished Business.

The Secretary of the Council, Dr. H. L. Ducrocq, read the following report:

New Orleans, May 11, 1905.

A meeting of the Council of the Louisiana State Medical Society was held at 12 o'clock (noon), with Dr. Graner as Chairman, and Drs. Sitman, Vance, Harrell, Archinard, Gardiner, present, and Dr. Ducrocq as secretary.

This Board of Councillors is organized and ready for business.

It is the sense of the Council that the report of Dr. Vance, coming from the Shreveport Medical Society, be handed in with the Council's approval, to be acted upon at this session. This report deals with the resolution concerning State and Parish licenses paid by physicians of Louisiana. Doctors are called upon as public servants of the people to give away their labors to charity, and, as benefactors of their respective communities, should be dispensed from paying any license.

The Council also requests that the Secretary of the Louisiana State Medical Society furnish each councillor with as many copies of the proposed medical bill as there are parishes in his district.

We recommend for election as a member of this Society Dr. J. A. Gaar, of Weston, Jackson Parish.

H. L. DUCROCQ, M. D.,
Secretary of the Council.

On motion, duly seconded, Dr. Gaar was elected a member of the Society.

Dr. Vance's resolution was then taken up.

DR. E. D. MARTIN moved that the report be referred to the Legislative Committee, so that they may take such action as they saw fit.

DR. DOWLING assumed the chair.

Discussed by DRS. ARCHINARD, CHASSAIGNAC, LARUE, WOODALL and BRUNS.

DR. MARTIN withdrew his motion.

DR. CHASSAIGNAC resumed the chair.

DR. MCVEA read the following resolution:

WHEREAS, It has pleased Almighty God to remove from our midst an honored member of this Society, DR. JOHN CALVIN ALLEN, of Baton Rouge, therefore be it

RESOLVED, That we deeply deplore the untimely death of Dr. Allen, and that we extend to his bereaved family our heartfelt sympathy.

RESOLVED, That these resolutions be spread upon the minutes and a copy be sent to the family of our deceased member.

Carried.

(John Calvin Allen was born at Live Oak, Livingston Parish, Louisiana, November 10th, 1857. He was educated at the Louisiana State University, and the Louisville Medical College, Class of 1883. He practiced at Slaughter, La., until 1897, when he went to the New York Post Graduate and came to Baton Rouge in March, 1898. He leaves two sisters, Mrs. T. P. Singletary and Mrs. Alice Dupree, of Baton Rouge, and Dr. Lawson Allen and Mr. D. M. Allen, if Greensburg, La.)

Dr. E. D. Newell introduced a resolution thanking the Orleans Parish Medical Society, the Medical Faculty of Tulane University, the New Orleans Polyclinic, the New Orleans College of Pharmacy and the medical profession of New Orleans for the courtesy and attention accorded the members of the State Society.

Carried.

Dr. Dowling introduced the following resolution:

Resolution Concerning the Eye, Ear, Nose and Throat Hospital.

Whereas, The steadily increasing demands upon the space and the resources of the Eye, Ear, Nose and Throat Hospital of New Orleans have now reached a point where it is no longer possible to conduct the work in the old dwelling-house, which up to now has been its home; and as the Board of Trustees, perceiving this, has finally determined to ask of the ever-charitably inclined people of New Orleans and of Louisiana the sum of $150,000 to erect a new and modern hospital, which will not only increase the charitable and the scientific possibilities of the institution, but will be an ornament and credit to the Commonwealth as well;

And as the physicians of Louisiana best know the benefits the institution has conferred upon the poor of all the parishes, its scientific value, and what it has accomplished in teaching and equipping a host of practitioners, who are now competent to relieve, and are, by their labors, relieving, this class of diseases in the towns of this and our neighboring States, and who look upon the Eye, Ear, Nose and Throat Hospital of New Orleans as their second Alma Mater; be it

Resolved, That the Louisiana State Medical Society commends to the generosity of the people and the profession of Louisiana the

Eye, Ear, Nose and Throat Hospital of New Orleans; that it urges upon the physicians of the different parishes the duty and privilege of assisting to raise from the police juries and people of their respective parishes a part of the sum necessary to erect a new and suitable hospital building, so as to permit the proper carrying on of the evergrowing charitable, teaching and scientific work of this institution.

Discussed by DRS. BRUNS and DOWLING.

Upon motion, duly made and seconded, the resolutions were unanimously adopted.

DR. MAYER introduced the following resolution:

RESOLVED, That it is the sense of this body that a law should be enacted protecting the secrecy of medical communications to doctors of medicine in courts of justice, and that this resolution be referred to the Committee on Legislation.

Carried.

DR. MAYER introduced a resolution with reference to mapping out the work of the ensuing session, with special reference to the subjects of tuberculosis, typhoid fever, etc.

Moved that the resolution be referred to the Committee on Scientific Work.

Carried.

DR. MAYER introduced a resolution to revive the section on Maritime and Inland Sanitation.

Carried.

DR. KOHNKE introduced a resolution in reference to vaccination of school children, and moved it be referred to the Committee on Legislation.

In explanation of his resolution, Dr. Kohnke said that the present law did not provide for vaccination as a prerequisite to entrance of pupils into the public schools, unless smallpox is prevailing at the time, and the Board of Health demands it. Whether or not it will be possible to get such a law passed, the Legislature would decide.

Discussed by DRS. TOLER, MCVEA and KNOLLE.

Carried.

DR. MCGUIRE stated that a number of parish societies reported honorary members, and he desired instructions as to what should be done in these cases, as he did not find any provision for exempt-ing them from the payment of dues. He therefore moved that the parish societies be required to pay to the State Society for such members as they wished to carry as honorary members, provided the members desired the benefits of membership in the State Society.

Motion seconded.

An amendment was offered to exempt those whose dues were now standing.

The amendment was accepted.

DR. MAGRUDER: It seems to me that it would hardly be fair for the active members to have to pay the dues of the honorary members.

DR. McVEA: A case in point is that of our Society. We have three honorary members. The first is 78 years old, and never goes out after dark. Rather than not have him on the roll we made him an honorary member. We do not feel that it would be just for us to pay three dollars a year for this member. Besides that, we have two doctors who are veterinarians.

THE PRESIDENT: In looking into the constitution, it seems to the chair that it would be impossible for us to take any action, except by way of an amendment to the constitution.

The President then read the provisions of the constitution with reference to members.

The President ruled that the parish societies could prescribe their own provisions as to honorary memberships, but that before such memberships would be recognized by the State Society the constitutional provisions would have to be complied with.

The motion was then withdrawn.

DR. LARUE: There is a bill for one hundred dollars ($100) against the Louisiana State Medical Society for services rendered at the last Legislature. This was discussed by some of us yesterday afternoon, and we would like to know what is the sentiment of the Society with reference to paying the bill.

Discussed by DRS. FENNER, NEWELL, GUTHRIE, McVEA, MARTIN, OECHSNER, DEMPSEY, McGEHEE, HARRELL, BARRIER, LEBEUF, LARUE, CARRUTH, THIBAUT andMcGUIRE.

Moved by DR. KOHNKE that the bill be paid.

Motion amended so as to change the amount to fifty dollars.

Amendment accepted and carried by a vote of 48 to 28.

Motion to reconsider was lost.

The Society then went into executive session to consider some matters brought up by Dr. GUTHRIE, after which the order of business was resumed.

DR. FENNER, Chairman, presented the following report:

In the matter of the proprietary article referred to your Committee, we desire to report that we can find nothing in the advertisement which is unethical or which should cause its rejection by a strictly proper medical journal.

(Signed) E. D. FENNER, M. D.,
HENRY DICKSON BRUNS, M. D.,
NORWOOD K. VANCE, M. D.

Moved by DR. LEBEUF that the report be adopted.

Discussed by DRS. DEMPSEY, FENNER and DOWLING.

Carried.

The Secretary read the following resolution:

WHEREAS, In view of the recent advances made in the treatment of chronic and incurable diseases by electro-therapeutics and X-Ray, and in view of the fact that many members of the Society are interested in and make use of those agents, be it

RESOLVED, That a section on Electro-Therapeutics and X-Ray be established as a regular part of the annual program.

On motion, amended to read "X-Ray and Electro-Therapeutics."

Carried.

The Secretary read a telegram from Dr. G. R. Tolson, as follows:

"Have committee appointed to go to Legislature on Tuberculosis."

Moved by DR. MCVEA that this be referred to Committee on Legislation.

Carried.

DR. DOWLING: For the information of the Society, I will state that I attended the Texas State meeting, and they had secured a fare of one fare plus ten per cent. I have a program from the Arkansas State Society in which they say "one fare plus fifty cents for the round trip." We have never received a better rate than a fare and a third. It seems to me that we ought to be able to get this rate. When the committee came to Shreveport I could not get the rate. I simply want to place this before the house.

Dr. Oechsner: I move that a vote of thanks be extended to the press for their courteous treatment.

Carried.

Dr. Mayer placed before the house for election to honorary membership the President of Tulane University of Louisiana, Dr. Edward Boone Craighead.

Motion duly seconded, and carried by unanimous vote.

Dr. Perkins: With regard to what Dr. Dowling has said, I think it would be well to tell you that we have tried our very best to get a rate better than we have been getting, but we could not do so.

Dr. Guthrie: We had a paper yesterday on embalming, calling attention to certain shortcomings in regard to the embalming of the dead. I think we will all agree that the law in regard to embalming is too lax, and should be so amended as to make it effective against these abuses.

Dr. Larue presented for honorary membership the name of Dr. John J. Castellanos.

Moved that Dr. Castellanos be elected.

Carried.

Dr. Oechsner: In regard to the remarks of Dr. Archinard in his paper, I wish to offer the following resolution:

"Resolved, That we deprecate the system which the wholesale houses have adopted of putting on the market sera, the efficacy of which has not been demonstrated."

Moved that above be adopted.

Carried.

Dr. Perkins: I move that the papers on the desk and not read, or that may reach the Secretary immediately after adjournment, be considered as read by title, and referred to the Committee on Publication.

Motion seconded and carried.

Dr. Smart: I move that we proceed to the installation of new officers.

The President: I appoint Drs. McVea and Perkins as a committee to escort the President-elect to the chair.

The PRESIDENT: I hereby install Dr. Ducote as your President for the coming year. All I can tell him is that I hope he will have the same courtesies and kindnesses tendered him as President as have been tendered to me.

DR. DUCOTE: I can hardly think how you came to select such an old man as your presiding officer. I thank you for the honor conferred upon me and I feel that it is a great honor to be your President. I wish to assure you that I shall do my utmost to give impartial rulings and also to advance the interests of the society. To do that I shall look to you for advice and support. I thank you for the honor.

DR. DUCOTE then took the President's chair.

The other officers were then installed.

The delegates to the American Medical Association were then installed.

The session then adjourned, to meet at New Orleans on May 8, 9 and 10, 1906.

SPECIAL ANTI-MOSQUITO MEETING.—At the request of the majority of the Council and of the officers and many members of the society, the President has issued the following self-explanatory letter:

COTTONPORT, LA., Nov. 21, 1905.

By virtue of the authority vested in me as President of the Louisiana State Medical Society, I hereby call a special meeting of that body to take place in New Orleans on Tuesday, at 9:30 a. m., February 6, 1906, to prepare for sanitary measures to prevent infection in the State during the coming year and to urge necessary changes in medical legislation.

All members are earnestly requested to make unusual efforts to attend. The subjects for discussion are of vital importance to the people and the medical profession.

This meeting will not interfere with our annual meeting in May. It is intended more particularly to discuss yellow fever and the part the mosquito doctrine teaches and devise means and measures to prevent a recurrence of an epidemic, also to revise the Sanitary Code and bring it to the present advancement of the medical sciences.

C. J. DUCOTE, M. D., President.

Medical News Items.

THE NEW INSANE HOSPITAL AT PINEVILLE, LA., WILL BE OPENED DECEMBER 20.—The day of opening has been changed from January because a number of inmates confined in jails throughout the State require more room than the Jackson Asylum offers. It is expected that two or three hundred inmates will be admitted as soon as the institution is ready.

RECIPROCITY IN STATE MEDICAL BOARDS.—The Board of Regents of New York and the State Board of Medical Examiners of New Jersey, at Trenton, October 16, decided to indorse each other's examined licentiates without further examination, beginning January 1, 1906. The medical license of New Jersey is indorsed, at this time, in lieu of further examination, by Maine, Vermont, Delaware, Virginia, South Carolina, Texas, Ohio, Illinois, Michigan, Minnesota, Wisconsin, Kansas and Colorado. New Jersey will indorse the medical license issued by any State, after examination, whose educational, examining and licensing requirements are substantially equal to or higher than those of New Jersey, irrespective of reciprocity, provided the applicant complies with the conditions of indorsement. The standard of requirements of New Jersey consists of a high school diploma issued after four years of study, and a medical diploma issued after four courses of lectures of at least seven months each, in four different calendar years, in a medical college of approved standing.

LEPROSY IN THE PHILIPPINES.—In the last report from the Philippines a total of 3,763 lepers is reported from various provinces. Of these the vast majority were native Filipinos, the exceptions being one European and one Chinaman. In the San Lazaro Hospital, in Manila, there were 232. Among these were the above European and Chinaman.

THE ALVARENGA PRIZE OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.—The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize will be made on July 14, 1906, provided that an essay deemed by the committee of award to be worthy of the prize shall have been offered. Essays intended for competition may be upon any subject in medicine, but cannot have been published. They must be typewritten and must be received by the secretary of the college on or before May 1, 1906. Each essay must be sent without signature, but must be plainly marked with a motto and be accompanied by a sealed envelope, having on its outside the motto of the paper and within the name and address of the author. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the college; other essays will be returned upon application within three months after the award. The Alvarenga Prize for 1905 has been awarded to Dr. Chalmers Watson, of Edinburgh, for his essay entitled "The Importance of Diet; an Experimental Study from a New Standpoint."

INSANITY AMONG NEGROES.—The annual report of Dr. W. F. Drewery, Superintendent of the Central State Hospital, at Petersburg, Va., contains interesting statistics regarding the alarming increase of insanity among the negro population. The number of patients sent to the hospital during the year was 170 more than the previous year, showing an increase of about 50 per cent. The number in the hospital was 1,449, or 115 greater than the year before. The smallest number under care at any one time was 1,101 and the largest 1,305. The number present at the end of the year was 1,181, or eighty over the previous year. The growing prevalence of mental disease among the negroes is ascribed to physical conditions and degeneracy induced by indolent, unhygienic and immoral methods of life, as well as to the influence of heredity, rather than to any forms of mental stress or overwork.

THE A. R. ELLIOTT PUBLISHING COMPANY announce the consolidation of the *Medical News* on January 1, 1906, with the *New York Medical Journal* and *Philadelphia Medical Journal.* The *Medical News* was founded in 1843. Mr. Elliott is to be congratulated on his success in this strong combination of three of the largest weekly medical publications in the United States.

THE NEW ORLEANS COLLEGE OF PHARMACY OPENED ITS SESSION on November 2 with an attendance of forty-five students. At their meeting, held November 3 and 4, there were sixteen applicants and ten passed.

AT THE LAST MEETING OF THE MISSISSIPPI PHARMACEUTICAL BOARD, held November 2, there were twenty-eight applicants and only twelve passed.

PERSONALS: Among the visiting physicians in New Orleans lately were Dr. R. Stone, Amite, La.; Dr. Joseph Y. Porter, State Health Officer of Florida; Dr. J. A. Tucker, of Baton Rouge, and Dr. S. R. M. Kennedy, of Pensacola. Dr. Kennedy is a son of Dr. T. S. Kennedy, of this city.

Dr. L. O. Howard, Secretary of the American Association for the Advancement of Science, was in the city last month.

Dr. Thomas Y. Aby, Assistant Quarantine Officer at the Quarantine Station, at the mouth of the river, has resigned.

Drs. W. Kohlman, A. A. Pray, W. Sheppegrell and J. D. Bloom have returned from their vacation.

Dr. R. Matas has returned from an extended trip North and East.

Dr. Edmond Souchon, President of the State Board of Health, has returned after an absence of some weeks.

Dr. Hamilton P. Jones, who had charge of the Emergency Hospital, went East for a two weeks' vacation.

Dr. Hampden S. Lewis spent his vacation in Mexico and reports a pleasant time.

Dr. Isaac Ivan Lemann, after a year's sojourn in Europe, devoted to study, has returned to New Orleans and has resumed the practice of his profession.

Among those who have returned from their vacations are: Dr. A. W. DeRoaldes, from Europe; Dr. Isadore Dyer, from New York and Cuba; Dr. A. B. Gaudet, from Chicago and the West; Dr. S. M. Fortier, from New York; Dr. Paul L. Reiss, from Canada, and Dr. Milton Schlenker, from a European trip.

Dr. E. M. Hummel, recently a member of the staff of the State Insane Asylum, has returned from a six months' stay in Europe.

Dr. W. B. Robertson has returned from Ceiba, C. A., and will spend the winter here.

Dr. Felix Girard, of Lafayette, La., has gone to France.

Dr. W. T. Patterson has moved from Crowley to Morse, La.

Dr. R. C. Hodges has removed from Houston to Del Rio, Texas.

Prof. Rupert Boyce, Dean of the Liverpool School of Tropical Medicine, passed through New Orleans on his way home from Central America.

Dr. J. H. White was presented with a handsome silver service by the railroads here.

AT THE SEMI-ANNUAL MEETING OF THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS, held November 14 and 15, there were twenty-two applicants and sixteen passed the board. The following were the successful candidates: Miss Edith Loeber, Mrs. Clara T. I. Glenk, P. C. Schmidt, S. Atkinson, George C. Ballard, C. A. Wallbilich, Salvatore Schiro, J. C. Morey, W. J. Babin, J. B. Thompson, F. S. Shaul, O. E. Kauffmann, A. B. Sambola, J. B. Pratt, Charles H. Pickett and A. W. Brazier.

THERE WERE SIXTY-FOUR APPLICANTS TO PRACTICE MEDICINE BEFORE THE MISSISSIPPI Examining Board in November and thirty-nine passed.

Dr. and Mrs. M. H. McGuire are receiving congratulations of their friends on the birth of a boy.

MARRIED: Dr. P. Leonce Thibaut and Miss Loyola Richardson were married November 16.

DIED: Dr. E. S. Ranch, at Vicksburg, Miss., on October 20, aged 24 years. He was a graduate of Tulane. At the breaking out of yellow fever he went to Hamburg, Miss., because he was considered immune, having had it in 1898.

INTERNATIONAL MEDICAL CONGRESS.—The committee in charge of the International Medical Congress, which will be held in Lisbon from April 19 to 26, 1906, has written asking for the contribution of papers on the following medico-legal subjects and saying that as yet no titles of communications touching on any of these subjects have been received from this country:

The signs of virginity and of defloration in medico-legal relations.

Hand marks and finger prints; their medico-legal importance.

The medico-legal importance of the carunculæ myrtiformes.

The mechanism of death by hanging.

The value of bacteriologic examination of vulvo-vaginal discharges in the determination of venereal contagion.

The signs of death by drowning.

Ecchymoses in legal medicine.

Spontaneous and criminal abortions from a medico-legal point of view.

Medico-legal investigation of bloodstains.

The relations between the seat of cerebral contusions and the point of application of the agent which produced them.

Epilepsy in legal medicine.

The induction of abortion; when is it permissible?

The value of legal medicine in the study of criminal law.

The best legislation for the protection of the "medical secret" (the obligation imposed upon physicians to treat as inviolable all information concerning patients obtained while in the discharge of their professional duties).

The effects of the civil and penal law towards the newborn living infant.

Distinction between the natural openings in the hymen and tears of this membrane.

Criminal vulvar copulation.

Organization of medico-legal services.

If any of the readers of this communication intend to take part in the discussions of this section of the congress, or to prepare papers for it on any of the subjects mentioned, or on any other subject in medicine or surgery, he should inform the Secretary of the American Committee. RAMON GUITERAS,

Secretary American National Committee.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

The Detection of Poisons and Strong Drugs, by DR. WILHELM AUTENRIETH. Authorized translation from the third enlarged German edition, of WILLIAM H. WARREN, Ph. D. P. Blakiston's Son & Co., Philadelphia, 1905.

The work has been designed primarily for beginners, and students of medicine and pharmacy will find it all that they desire. Many drugs which are not poisons in the strict sense of the term, such as quinin, phenacetin, salicylic acid, etc., are included. The detection of blood is briefly but well considered, and the biological detection of blood is also included to give the work completeness. STORCK.

The Era Key to the U. S. P. Eighth decennial revision. Pharmaceutical Era, New York, 1905.

A new edition of the well-known "Era Key to the U. S. P.," whose object is to further the employment of the official preparations of our national standard, the United States Pharmacopœia, the eighth revision of which is now in force, comes in vest-pocket size and gives in a "nutshell" all the essential information required by the physician who desires to prescribe pharmacopœia remedies. The physician will find it helpful in his effort to prescribe official pharmaceutical preparations.

The National Standard Dispensatory, by HOBART AMORY HARE, B. Sc., M. D., CHAS. CASPARI, JR., Phar. D., and HY. H. RUSBY, M. D. Lea Brothers & Co., Philadelphia and New York, 1905.

The successor of the *National Dispensatory* we all know; this work contains every article of the new U. S. Pharmacopœia, and covers also the unofficial drugs and preparations which are largely in use today; hence, contains information about all substances now used in medicine.

The subjects of alkaloids and fixed and volatile oils have been very fully covered and the new synthetic remedies have received due attention.

The action and uses of drugs have been presented in a compact manner, and are made immediately available under the name of each disease in a complete therapeutical index.

By a happy idea, the illustrations of typical specimens of drugs follow as much as possible their appearance as they appear in commerce.

An extensive general index is furnished. Altogether it is a volume that no physician can well dispense with, and yet a druggist can scarcely dispense without. C. C.

Hollis' Epitome of Medical Diagnosis. A manual for students and physicians. By AUSTIN W. HOLLIS, M. D., attending physician to St. Luke's Hospital; to the New York Dispensary, etc. In one 12mo volume of 319 pages, with 13 illustrations. Cloth $1.00, net. Lea Brothers & Co., Philadelphia and New York, 1905.

This volume is the fifteenth of the series of Lea's Series of Medical Epitomes, edited by Victor C. Pedersen, M. D. It naturally does not claim originality, but it embodies an earnest effort to give a clear, accurate compendious covering of the essentials of its subjects, presented with a due sense of the relative importance of its various branches.

Disease and abnormal conditions are taken up in regular sequence, and physical and clinical signs and symptoms are clearly pointed out with full explanations of their significance.

In addition to physical methods, the author gives directions for laboratory investigations, blood tests, bacteriological and chemical examinations, etc., and as one goes carefully through the book the wonder grows at the enormous amount of clear-cut, modern, well-arranged information which has been compressed between its covers.

Illustrations are used throughout the volume wherever the understanding can be better helped by the combination of text and pictures.

E. M. D.

General Medicine. Practical Medicine Series. Vol. I. The Year-Book Publishers, Chicago. 1905.

The past year furnishes valuable contributions to the subjects included in this number, viz.: Disease of the respiratory organs of the circulatory organs, of the blood and blood-making organs, general infectious diseases parasitic diseases, metabolic diseases, diseases of the kidneys and of the ductless glands. The value of these contributions is evinced by their corroborative and practical bearing rather than by any new suggestions or discoveries made by the writers. Attention is again called to the fact that this volume is intended to place before the reader a review of the literature of general medicine of the past year in a condensed form, and still full enough to convey the full meaning of the authors.

As far as possible the condensed articles are so arranged as to make the text continuous and smooth, but this cannot be done in all cases, and in no event is padding used, for the book is what its name implies—a review of the best literature of medicine of the year.

The present volume is one of a series of ten issued at monthly intervals, and covering the entire field of medicine and surgery, each volume being complete for the year prior to its publication on the subject of which it treats. The series is published primarily for the general practitioner, at the same time the arrangement in several volumes enables those interested in special subjects to buy only the parts they desire.

E. M. D.

Color-Vision and Color-Blindness. A Practical Manual for Railroad Surgeons. By J. ELLIS JENNINGS, M. D. Second edition. F. A. Davis Company, Publishers, Philadelphia, Pa.

In the second edition of this work the author has thoroughly revised the first publication and made several important additions to it. The book is remarkably free from superfluous matter, such as elaborate discussions of theories, and is entirely practical in its bent. It should be very valuable to every physician interested in the detection of defects of color-vision. ROBIN.

Manual of Diseases of the Eye, by CHARLES H. MAY. Fourth edition. William Wood & Co., 1905.

The appearance of a fourth edition of this work argues well for its worth and appreciation by the profession. Though necessarily abridged in its character, we find that nothing has been left out, especially in the commoner diseases of the eye, necessary for the full understanding of the subjects. The matter is well abreast of the times, and the teaching sound in every way. Students will find it a very useful book. ROBIN.

Publications Received.

State Examinations for License. Bulletin of the American Academy of Medicine, August, 1905.

Fifteenth Annual Report of the Eye, Ear, Nose and Throat Hospital at New Orleans, 1905.

Twenty-eighth Annual Report of the Board of Health of the State of New Jersey, 1905.

A Guide to the Organic Drugs of the U. S. Pharmacopoeia.—Pharmacology of the Fluid Extracts, by J. S. Wright, M. D. (Eli Lilly & Co., Research Department, Indianapolis, 1905.)

A Manual of Acute Poisoning, by J. W. Wainwright, M. D. (E. R. Pelton, N. Y., 1905.)

Report of the Department of Health of the Isthmian Canal Commission for the Month of April, 1905, by Col. W. C. Gorgas.

Ophthalmic Neuro-Myology, by G. C. Savage, M. D. (Published by the author.)

Reports of the Department of Health of the Isthmian Canal Commission for the Months of May and July, 1905.

Index Catalogue of the Library of the Surgeon General's Office, U. S. Army.

The Era Key to the U. S. Pharmacopoeia. (Originated and Compiled by the Pharmaceutical Era: D. O. Haynes & Co., Publishers; New York.)

Medical Diseases of Egypt, by Dr. F. M. Sandwith. Part I. (Published by Henry Kimpton, London, 1905.)

Memoria de Los Trabajos Ejecutados por el Consejo Superior de Salubridad en el Ano de 1901-1902-1903-1904.

An Improved and Accurate Method of Staining Blood Films, by E. Thum, M. D. (Published by Palisade Mnfg. Co., Yonkers, N. Y.)

Cleft Palate and Hare Lip, by W. Arbuthnot Lane, M. S., F.R.C.S. (Published by The Medical Publishing Co., Ltd., London, 1905.)

Reprints.

Contribution to the Plastic Surgery of the Urethra, by Dr. G. F. Lydston.

Why Surgical Fixation of a Movable Kidney Will Not Relieve Dyspeptic and Nervous Symptoms, by Charles D. Aaron, M. D.

The Chemistry of Digestion; (2) *How to Palpate a Movable Kidney*, by C. D. Aaron, M. D.

The Bacteriology of the Blood in Typhoid Fever, by Drs. Warren Coleman and B. H. Buxton.

The Vapor Method of Anesthesia, by James T. Gwathmey, M. D.

Paraplegia from Fracture of the First, Second and Third Dorsal Vertebrae; Seven Other Fractures, Etc., by Guy Hinsdale, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

For October, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	2	1	3
Intermittent Fever (Malarial Cachexia)	1	1	2
Smallpox		1	1
Measles			
Yellow Fever	57	3	60
Whooping Cough			
Diphtheria and Croup	6		6
Influenza	2		2
Cholera Nostras			
Pyemia and Septicemia	1		1
Tuberculosis	41	48	89
Cancer	13	9	22
Rheumatism and Gout	2		2
Diabetes			
Alcoholism			
Encephalitis and Meningitis	7	2	9
Locomotor Ataxia	1		1
Congestion, Hemorrhage and Softening of Brain	16	9	25
Paralysis	2		2
Convulsions of Infants	1		1
Other Diseases of Infancy	12	8	20
Tetanus	2	11	13
Other Nervous Diseases	1		1
Heart Diseases	41	38	79
Bronchitis	5	2	7
Pneumonia and Broncho-Pneumonia	9	11	20
Other Respiratory Diseases	2	3	5
Ulcer of Stomach		2	2
Other Diseases of the Stomach	2	3	5
Diarrhea, Dysentery and Enteritis	12	9	21
Hernia, Intestinal Obstruction	2	2	4
Cirrhosis of Liver	8	3	11
Other Diseases of the Liver	1		1
Simple Peritonitis	1	3	4
Appendicitis	4		4
Bright's Disease	24	15	39
Other Genito-Urinary Diseases	2	4	6
Puerperal Diseases	3	2	5
Senile Debility	21	17	38
Suicide	3	1	4
Injuries	17	10	27
All Other Causes	15	8	23
TOTAL	339	226	565

Still-born Children—White, 22; colored, 18; total, 40.

Population of City (estimated)—White, 239,000; colored, 86,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 17.02; colored, 31.53; total, 20.86.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**30.03**
Mean temperature	**70.**
Total precipitation	**5.95 inches.**

Prevailing direction of wind, northeast.

New Orleans Medical and Surgical Journal.

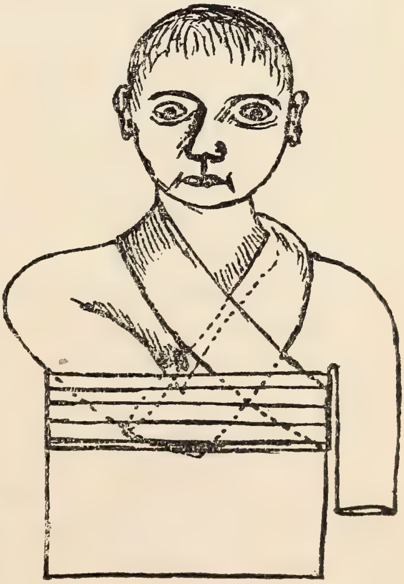
VOL. LVIII. JANUARY, 1906. No. 7

Original Article.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of this article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

A Simple Bandage for Fractured Clavicle Particularly in Children.

By DR. B. A. COLOMB, Union, La.



The bandage is made from one piece of stout cloth, three yards long for a child and two and one-half to three inches wide. Sufficient of the bandage is folded over at one end to extend the full length of the forearm. This is sewed along the bottom, the lapel end and greater portion of the top, leaving an opening into which the band and arm can be easily passed. Once the arm is inside the sleeve a safety pin closes the opening more snugly around the arm, so as to prevent its removal. The method of application is explained by the diagram. A few safety pins where the folds cross make the bandage secure.

Clinical Reports.

Notes On A Case of Esophageal Stenosis.

By J. T. HALSEY, M. D., New Orleans.

X, forty-three years of age, married, white, lawyer by occupation. Previous history: Left-sided pneumonia twenty-three years ago. Malaria nineteen years ago, of short duration. One severe attack of acute gastritis twenty-two years ago. No venereal diseases nor other infectious diseases as far as known.

Habits: Practically total abstainer. Smokes and chews. Moderate coffee drinker. Sedentary life.

Present illness: For past three or four years indigestion at times characterized by "fullness in stomach" coming on several hours after eating. For two years patient has noticed that rapid eating was followed almost immediately by slight discomfort. Sixteen months ago an attempt to drink a glass of cold beer produced most uncomfortable sensations and it was impossible to drink the whole amount. "Felt as if it had stopped halfway down." For three months past patient has been troubled with increasing frequency by regurgitation of food or sour (?) fluid, either immediately after eating or drinking, or several hours later. Amount regurgitated usually about one or two ounces, at times a cup or glassful, and on one occasion nearly a pint. There is no nausea and the regurgitation is to a certain extent controllable.

Of late this regurgitation has occurred very frequently, one or more times between nearly all meals. There has been no pain, but there is at times a sensation of indefinite discomfort referred to the episternal notch.

Patient has lost about ten pounds in last three or four months.

Physical examination: Patient fairly well nourished, apparently in fairly vigorous condition of health and strength. Examination of thorax negative, no signs of aneurism or of abnormal dullness. Examination of abdomen shows an enteroptosis; right kidney readily palpable, stomach about normal in size, but upper border three inches above, lower border one-half inch below, the navel. Lower abdomen prominent, epigastric region flat. Patient still wears a truss although hernia which was at one time present has given no trouble for fifteen years. Auscultation of stomach during and after drinking a glass of water failed to give sounds of water entering the stomach within the normal limit of time. Sounds of swallowing could be heard down along the spine to level of eighth dorsal vertebra.

X-ray examination by Dr. J. B. Guthrie was made, the patient having first swallowed a mixture of oatmeal jelly and bismuth. (See plate.) About eight specimens of regurgitation material were examined chemically and microscopically; all reacted neutral or very faintly acid (like saliva). There was never any free HCL, or an acidity of more than 1.0*c.c.* (1/10 N alk to 100*c.c.*). Blood found only once, then only a very small amount in a speciment regurgitated after considerable effort.

One hour after test breakfast stomach tube passed and when end appeared to be about two to four inches above cardia about two and a half ounces of *neutral* reacting food and fluid obtained. Tube then passed into stomach and a few drachms of fluid obtained. This fluid gave a strong reaction for free HCL.

The history of the case and the results of the physical, X-ray, chemical and microscopical examinations leave little or no doubt that the case is one of stenosis or stricture low down in the esophagus with dilation or diverticulum. The nature of the obstruction is less easy to determine. By exclusion the cause may, in this case, be considered to be a stenosis of nervous or spasmodic character, or an organic stricture, in nature either benign or malignant. Against spasmodic strictures the absence of other nervous manifestations and the existence of marked dilatation speak very strongly. Against a benign stricture there is absence of history or evidence of any trauma either mechanical, chemical or infectious. Carcinomatous stricture of the esophagus is with difficulty reconcilable with the long existence of the symptoms (certainly sixteen months and probably two years) with the patient in its present good condition. The negative findings of blood, the absence of pain, and the comparative youth of the patient are also against the diagnosis of malignant disease.

The patient was advised to seek a surgical opinion at an early date, but concluded for various reasons to postpone doing so for the present.

Report of a Case of Acute Tetanus.

By DR. PAUL E. BECHET, New Orleans.

I wish to report the following case of acute tetanus for two reasons. 1st. Because of the large doses of antitoxin used. 2nd. Large doses of physostigmin salicylat were given hypodermically with benefit and no apparent ill effect.

J. W., *Aet.* 10. Family history good; previous history, always healthy; present illness: On August 25 while jumping off a car he ran a splinter into his bare left foot. His father removed about an inch of the splinter a few hours after, and did not bring him to me before September 13, thinking all of the splinter had been removed. On examination I found a punctured wound in the left foot, from which a seropurulent fluid was oozing; there was considerable inflammation present, and also a good deal of pain. On using the probe it passed into the wound to the depth of about an inch. The general symptoms were undoubtedly those of acute tetanus, marked trismus, rigidity of the muscles of the neck, and risus sardonicus being present. I immediately gave him 30*c.c.* of antitoxin subcutaneously and 10 *c.c.* in the wound. Tinct. of physostigma, gtts. v. were prescribed every three hours. Early the next morning, September 4, under chloroform, I made a free incision, and removed a large jagged splinter, about an inch long and very thick, and a quantity of foul pus. I then curetted the wound thoroughly, irrigated it with a 1-1000 bichlorid solution, and cauterized it with pure carbolic acid, followed by absolute alcohol. Thirty *c.c.* of antitoxin were given at the same sitting. physostigmin salicylat gr. 1-50 and atropin gr. 1-200 were given hypodermically every three hours, and the tinct. physostigma was stopped. The same afternoon at 6 p. m., 30 *c.c.* of antitoxin were given in the buttocks. On the morning of the next day, September 15, the case seemed hopeless, there was marked retraction of the head, a lead pencil could not be passed between the teeth, the temperature was 105 degrees in the axilla, and sardonic smile had increased. I gave him 30 c.c. of antitoxin, however, and a few hours later called on Dr. Delaup, who promptly responded, and under chloroform we gave him an intraspinal injection of 20 *c.c.* of the antitoxin, and 10 *c.c.* in the wound. He passed a fairly quiet night, the eserin and atropin being kept up every three hours. The next morning at 8 a. m., September 16, the muscles of the back became involved, the opisthotonos lasting some time. I arrived just as the convulsion was ending, and after waiting a while gave him 30 *c.c.* in the buttocks. Later in the afternoon, Dr. Delaup and I injected 10 *c.c.* in the spinal canal, and 20 *c.c.* in the wound, which was clean and healing well. That night he rested well, sleeping at times. The next morning, September 7, I found him much better, the temperature was normal, the muscles of the jaw and face slightly relaxed. I gave him 30 *c.c.* of antitoxin in the buttocks, and in the afternoon on visiting him again found a marked improvement. The eserin and atropin were discontinued. That night he slept well, and the next day the jaws were well relaxed and well established. In conclusion I wish to call attention:

1st. To the large doses of antitoxin—250 *c.c.* in 120 hours.

2nd. Not a dose of morphin, chloral, or the bromides was given.

3rd. To the prolonged use of physostigma salicylat, gr. 1-50, every three or four hours, during three days, without ill effect; this I think was due to my giving atropia, its physiological antagonist, at the same time.

Louisiana State Medical Society Proceedings.

(EDITED BY PUBLICATION COMMITTEE).
P. L. Thibaut, M. D., Chairman.

Amputation of the Cervix Uteri for Hemorrhage Complicating Chronic Metritis.

By C. JEFF MILLER, M. D., New Orleans.

Persistent hemorrhage from the uterus is a condition often quite beyond the usual palliative resources and must be controlled even though a radical surgical operation is necessary. The indications for treatment are clear when the cause is found to be fibroids, placental masses, malignant growths, tubercular ulcerations, etc., but, when changes take place in the myometrium, either as a result of developmental defects, infection, or the natural phenomena attending or preceding the menapause, the pathology is by no means well understood, nor are the indications for treatment well defined.

It is to this class of cases that attention will be directed; cases generally described as chronic endometritis and curetted one, or many times, without the slightest benefit.

The clinical features of this condition are those associated with endometritis; the pathological features belong under the head of chronic metritis, a term quite difficult to satisfactorily define. It stands not so much for definite inflammatory processes as for certain changes of a permanent nature in the quality and quantity of the various elements which go to make up the uterus as a whole.

The main symptoms of chronic metritis are menorrhagia, intermenstrual hemorrhage and leucorrhea, although every sign may subside for months.

Pain may not be present unless the case is one of primary disease of the appendages. Tenderness in palpation is usually absent in uncomplicated chronic metritis. Dysmenorrhea is not a common feature nor is sterility the rule.

Changes in the myometrium that prompt hemorrhage. The general opinion prevails that infection of the endometrium underlies almost all of the affections to which the uterus is heir, but study of the endometrium to harmonize clinical, macroscopical and microscopical findings has upset much of the theory of endometritis and has turned attention to the deeper structures as possibly the primary cause with the endometrical changes as a secondary manifestation. Theilhaber (*Archiv. fur Gynakol,* 1903), who has done the most notable work in the investigation of chronic metritis, offers the following classification of changes in the myometrium as the cause of hemorrhage.

a. Insufficient development of the musculature in the years immediately following puberty.

b. Atrophy of the musculature in after life, or after exhausting diseases, etc.

c. Increase of connective tissue with retrograde changes in the musculature following frequent pregnancy.

d. Chronic disease of the appendages, etc.

e. Interstitial edema of the musculature in acute and subacute diseases of the appendages.

Under the head of hyperemia of the uterus he adds:

a. Through over-development of its vessels.

b. Through vaso-motor dilatation of the vessels.

Most cases, he believes, come under these two heads, and as proof that chronic metritis, so-called, is not as is generally thought secondary to endometritis, he offers the results of the examination of more than 100 uteri by his assistants, Meier, Hollinger and Lorentz, who proved that changes in the mucosa are rare in cases of menorrhagia and metrorrhagia. They found an increase in the size of the organ, decrease of the uterine muscle, increase of the fibrous tissue, increase of the uterus and in its vascularity.

In Fothergill's (*The Practitioner,* 1904) review of chronic metritis he relates in detail Anton Meier's results (mentioned above) obtained in sixty-one uteri examined to ascertain the variations which occur in myometrium. The uteri were obtained from subjects of ages from five months to seventy-five years. He found the uterin muscle reduced in quantity after each labor, and that exhausting diseases also exert an unfavorable influence on it. For many years before the menopause the muscle is reduced in quantity.

In cases of pyosalpinx muscular atrophy was observed and while fibromyoma usually caused an increase of muscle there was often relative increase of connective tissue in cases when hemorrhage was pronounced. The arterial walls were thickened, very often in quite young women, and were found to also thicken as age advanced after thirty-five years.

This goes to prove Theilhaber's clinical observation that the increase of fibrous tissue is a physiological process just before and after the menopause, and when the changes proceed normally atrophy follows, but when the muscle is unable to control the blood supply, hyperemia with consequent hypertrophy appears and very frequently ends in hemorrhage. The primary change is atrophy, the one unvarying factor in approaching senility of the sexual organs. This should be accompanied by similar changes in the blood vessels, with consequent decrease in the blood supply, and if for some reason the vascular changes are delayed engorgement necessarily follows.

To those who originally accepted the classification of Pozzi, in which a type described as angiomatous metritis appeared, this more accurate table of Theilhaber will be acceptable. Pozzi described in this class cases in which the uterus was voluminous and thick walled, but of normal consistency. There was no hypertrophy of the mucous membrane, the epithelium was normal, but the vessels were numerous, dilated, and their walls showed embryonal character. New formation could be detected in the muscular structures.

A review of the opinions of various authorities leads to the practical conclusion that in many cases of persistent bleeding in so-called chronic metritis we are dealing with disturbed vascularity, rather than inflammatory changes, and the indications for treatment are to restore the equilibrium until natural, compensatory atrophy occurs.

Furthermore, the surgeon must carefully discriminate between cases due to disturbed vascularity and to infection when advising radical operations; for since hysterectomy has become the generally accepted treatment for infected cases, the uteri of many women are probably unnecessarily sacrificed.

I wish to mention the very satisfactory results obtained in ten cases of aggravated hemorrhage by high amputation of the cervix uteri.

There were among the number cases that some surgeons would have promptly submitted to hysterectomy, if we are to accept the indications for that operation offered by them. I was testing the lesser operation and endeavoring to exclude inflammatory complications of appendages as far as possible and found the results fully justified the simpler procedure.

If the appendages are diseased and the physical signs point to long standing inflammation, of course total ablation is to be considered, but when such complications can be eliminated, many uteri can be at least partially saved and the post operative dangers considerably reduced by removing the cervix and securing the vessels which control the major blood supply of the uterus.

Deep cervical tears which extend into the base of the broad ligament frequently give rise to persistent hemorrhage, and can be treated in a similar manner with corresponding results.

It is well to consider the influence of amputation on future pregnancies if the patients are still within the child bearing age.

Petroff (*Journ. d'Obst. et de Gyn.*, November, 1899, and *Amer.*

Journ. Obst. 1900) reports eighty-one cases in which amputation of the cervix was performed for symptoms of chronic metritis.

Menstruation became regular, less profuse, less frequent, and sensations of pain and weight in the pelvis disappeared. His personal experience leads to the conclusion that amputation of the cervix does not prevent pregnancy, but diminishes the chance of conception; that in the first half of pregnancy abortion is as frequent as with deep lacerations; that false pains occur during the last month of pregnancy, and that gestation rarely continues to term.

Such conclusions bar the operation in young women, except in aggravated cases.

Preventive Medicine.

By DR. QUITMAN KOHNKE, New Orleans.

However profound his learning or great his skill he has been chosen unwisely who, lacking the attributes of charity, courage or moral rectitude, selects for his life work the practice of a profession the noblest of all save one.

It has been said that the ideal physician spends his time in reducing his income by preventing disease. A strange definition, apparently, of the physician's attitude towards the community, but apparently only; a closer than merely superficial consideration convincing us not only of its correctness, but also that the attitude described is perfectly proper and natural, and, further, that no other relationship would be so. The reduction of income to be sure is incidental only, but can we imagine without horror a physician who would, because of the resultant effect on his income, fail to exert every reasonable effort to prevent disease?

We are told, also, that a good doctor is rarely a good business man, and it is meant in derogation, as of something lacking in the man, when in point of fact every instinct of the ideal physician is at variance with so-called "business principles," and the supposed lack of what are regarded as business qualifications is really the dominant presence of higher qualities, antagonistic to those deemed necessary for the accumulation of wealth. When physicians become rich as a result of their own efforts we usually find the financial acumen exercised in legitimate fields, outside the province of medicine.

Medicine is an unselfish profession, and every thought therein leads to a benefit conferred, not a profit derived. No other avocation yields such small monetary return for the amount and quality of energy expended. Save that of the ministry there is no profession from the members of which more unselfish devotion and sacrifice are expected or received. The soldier risks his life at the cannon's mouth for honor and glory, and in the excitement of battle and emulating companionship. His reward is public applause whatever the outcome. The statesman saves his country at the ballot box, periodically straining every nerve and sinew, and moral precept, for success. His hope is office and power and influence. The man of business engages in industrial enterprises of great value to humanity, devoting to such projects much time, labor and money. His incentive is personal gain. But the priest and the doctor do their work in quiet and alone, often with no other recompense in sight than is offered by a clean conscience, satisfied with well doing. And who shall say this is not the richest reward? It is the usual fee for service rendered in the domain of preventive medicine; at times, perhaps, accompanied with expressions of grateful appreciation, at others with expressions more like to personal abuse, and occasionally with threats of bodily injury.

The ideal doctor is not made by colleges or in hospitals; he is a product of experience. A little oldish, perhaps; old enough to have passed the period of striving for position, but young enough to do a full day's work—with an occasional night thrown in. Old enough to have profited by his own as well as others' trials, successes, disappointments and sufferings; young enough to hope that he and his work and the work of his kind may, in time, leave an impress on human nature for its betterment. He has no time or inclination to get rich and does not envy those whose souls are satisfied by the possession of wealth.

No man's influence for good is greater than that of the ideal doctor, because his judgment is always unselfish and he has no ax to grind. He would rather prevent disease than cure it, and he gives more advice than medicine.

If we were all ideal doctors the influence for good of the united medical profession upon the body politic and the body social would be a power that lawmakers would find it difficult if not impossible to withstand.

There is no question on which the medical profession can unite more appropriately, unselfishly and powerfully than that of preventive medicine; there is no branch of medicine that needs more than this the support of a united profession, for there is none that is so neglected by schools, hospitals, lawmakers and individual practitioners.

As good citizens we owe to the community in which we live that we throw the weight of our influence in all things in favor of the public weal, but more especially in matters with which we are technically familiar and professionally concerned.

Let us enter a moment into the causes of some things that are and should not be, and of others that are not and should be.

Laudation is ever welcome to the recipient and pleasant of expression, but to him who is sincerely desirous of giving to his life's work the best that is in him criticism is not offensive if it be just.

The bulk of medical teaching it must be admitted is absorbed by those branches of medicine which are devoted to the recognition and treatment of diseased conditions, and which have for their object the restoration of the patient to health. Too little attention is given to those which have for their object the prevention of the occurrence of disease. And the reason is obvious. The average under-graduate in medicine, anxious to qualify as quickly as possible so that he may practice his profession and earn a living by it, seeks that knowledge which promises to be most immediately useful and profitable to him, and relegates the balance to that period of study which is supposed to occupy the whole of a doctor's life.

No studies appeal to him more strongly than those which are termed "practical" (perhaps because they are nearer than others to the goal of actual practice), and his dominant thought, the stimulus to his energy and the directing force of his best effort is the desire to successfully treat conditions of actual disease.

Medical colleges are to a large extent, in this country at least, where they are supported mainly if not entirely by the fees of their pupils, readily responsive in greater or less degree to the law of supply and demand. They are apt to provide generously in their curriculum of studies for that supply which is most needed and, therefore, most demanded by the financial supporters of the college—the ones who pay the fees. This is business, and institutions of learning that are not endowed, or not sufficiently endowed to be independent, financially, must be subject to the laws of trade—which means that if the seller fails to respond to the buyer's demand the buyer will go elsewhere. This is perhaps brutally plain and sounds harshly when applied to an institution of learning, but the law of supply and demand is impartial and impersonal, it respects nothing and nobody.

To raise the standard of medical education the teachers of medicine, whose aims always for higher development, are compelled to adopt the methods of trade, and a combination for defense and protection of colleges is the result.

The opposing influences in medical education have always been, on the one hand, the demand for a quickly obtained diploma, and, on the other, the insistence, more or less modified by exigency, for a high standard of qualification.

In time, doubtless, the prevention of disease will receive the attention in the schools, the hospitals and in private practice that its importance warrants, but that this time has not yet arrived is plainly evidenced by the qualifications in this respect of the average recent graduate, the absence from hospitals of proper provision for the isolation of infectious diseases and the failure in private practice to prevent infection.

I do not mean to assert that preventive medicine receives no attention, but that it should receive more.

We hear too often of cases of infectious diseases so mild in character as not to require strict isolation to prevent a spread of infection; as though infection were possible only from cases presenting aggravated symptoms.

The impression that scarlatina is a mild form of scarlet fever, and varioloid essentially different in infectious possibilities from variola, must still be combated. Until a few years ago the supposed difference in infectiousness between severe and mild manifestations was even reflected in a local law requiring the reporting to the health department of certain infectious diseases, for, until corrected by amendment, the law on the subject designated malignant scarlet fever as reportable, excepting from this provision, by inference, all cases milder than those considered malignant.

Preventive medicine will never develop into a specialty, and its practice will always depend on the nearness of the average physician to the character of the ideal doctor. The likeness between the two will increase with time in spite of the commercial tendency of the age, but it may be hastened by the influence of early medical training, the requirements of examining boards and the attitude of the medical profession towards the subject.

The duty of the medical profession to the community and itself will not have been fully discharged until the principles of preventive medicine are illustrated by the proper isolation of infectious diseases in teaching hospitals, until legislative bodies look to representative medical men for advice and guidance in medical legislation, and until the individual physician consents to the protecton of the public against infection from his patient.

The management of hospitals, the boards of medical examiners and the paid officers of boards of health cannot be depended on to accomplish all that may be, without the moral support and active co-operation of the medical profession. Boards of health, whose function it is to encourage the practice of preventive medicine, will always, in practice, reflect the consensus of medical opinion. They will not do less than the medical profession desires and they cannot do more than the medical profession permits, and it is doubtless so, also, in the case of the other public functionaries. In the matter of protecton against imported diseases the all powerful incentive for the full measure of its strict application is community fear, but the practice of preventive medicine at home must depend on the love we bear to our neighbor, and our own self respect. I have an abiding faith in both, and while we are all aware of individual lapses, in high places and in low, I believe the average physician is growing more and more in likeness to the ideal doctor.

If preventive medicine does not receive its proper share of attention in the school, the hospital, the legislative body, or the household, the fault be where it may, the moral responsibility is with the medical profession. In the aggregate of its membership it has the wisdom to know, the courage to dare and the power to accomplish; it needs but the will to act. Its recommendations must be accepted as final judgments, for, whether or not we are, as individual factors, ideal, in association we strive to represent the ideality of medicine.

Society Proceedings.

Orleans Parish Medical Society.

President, DR. L. G. LEBEUF. *Secretary,* DR. ALLAN EUSTIS.
141 Elk Place, New Orleans.

In Charge of the Publication Committee, DR. ALLAN EUSTIS, Chairman,
DRS. JULES LAZARD and H. DUPUY.

The Publication Committee have been compelled to eliminate the discussions of the following papers, on account of lack of space.

MEETING OF SEPTEMBER 9, 1905.

DR. PHILLIP ASHER read a paper on:

"The New Pharmacopeia."

After a long series of unavoidable delays, the new pharmacopeia has been completed, the most serious amongst which was caused by the death of the following members of the Revision Committee and its adjunct committees: Dr. Edward R. Squibb, October, 1900; Dr. Charles Rice, chairman, September, 1901; Dr. Wm. S. Thompson, September, 1901; Dr. Wm. M. Mew, September, 1902; Dr. George W. Sloan, February, 1903; Dr. Walter Reed, chairman of Committee on Diphtheria Antitoxin, 1902; and Dr. Albert B. Prescott, February, 1905.

Owing to the long interval that must now naturally exist between the time of the convention and the issuance of this work, the title will in the future be changed to the numerical Decennial Revision, instead of being known by the year of convention; for instance, the present volume is termed the "Eighth Decennial Revision," in the place of the former method, the "1900 Pharmacopeia." Barring the few slight errors that are bound to occur in a work of such magnitude, we may unhesitatingly state that the present work is the acme of perfection, whether considered from the pharmaceutical point of view, chemical aspect, or in whatever light it may be regarded, as the objects of the convention have been fully carried out, and it adds one more link to the chain of American superiority, when compared with the similar standard of other countries.

It would be impossible in the short space of time allotted to this paper to give more than a passing résumé of its many changes; hence will endeavor in as succinct a manner as possible to touch upon such points as are of special importance to the physician.

The "Eighth Decennial Revision" becomes effective on and after September 1, 1905, and all drugs or chemicals purchased by the various departments of our government must conform to its standard. In quite a number of states it is also accepted as the legal standard. Unfortunately, in our state it is neither embodied in the pharmacy or medical laws. Would it not be advisable for this society to consider this phase? Changes in the pharmacy law have met with little success; perhaps, introduced as an amendment to the medical law it may be more fortunate. The change of the greatest moment to us is that all tinctures of potent drugs are now 10 per cent., the result of the International Conference for the Unification of the Formulas of Heroic Medication, held in Brussels in 1902, and the United States pharmacopeia is the first to adopt the result of its decision.

Gentlemen, consider well these changes, and what immediate measures must we adopt to prevent error. Unless special attention is called of both the physician and pharmacist, these changes may cause not only confusion, but result seriously.

Tincture of veratrum viride was formerly 40%; tincture aconite, 35%; these preparations still find great favor. Suppose you should prescribe either of them without specification, believing the new standard will be supplied and your patient has it compounded at a druggist's who is not abreast with the times? What might the result be? Or on the other hand, you should have in mind the old and he should furnish the new? Tincture of strophanthus was formerly 5%, it is now 10%. Should you have the old standard in mind and the new be furnished, your patient will receive twice as much as you had intended.

A feature has been introduced that will tend to greater uniformity; purity rubrics. Under the more important chemicals, drugs and their preparations, a fixed standard of purity has been given. By the old standard a physician could order a preparation from his pharmacist and it was a case of unknown quantity as to what he would receive. As one lot of drug from which his preparation was made might contain either a larger or smaller percentage of the active constituent than another lot of the same drug. With the present standard it does not matter whether the drug is old or new, high or low in active content, as the finished product must conform with the fixed standard. The following drugs and their preparations are now standardized, viz.:

Aconite, belladonna (leaves and root), cinchona, cocoa, colchicum (corn and seed), conium, guarana, hydrastis, henbane, ipecac, jalap, nux vomica, opium, pilocarpin, stramonium, scopola. Regarding nux vomica, I would state that the old pharmacopeia required that its solid extract, fluid extract and tincture contain a fixed percentage of total alkaloids, viz., strychnin and brucin; to-day only the strychnin is considered.

The solid extract is 5%, fluid extract 1% and tincture 1%. These preparations are lower in strength than before and naturally they will be of a lighter shade. In addition to the above drugs fixed oils, volatile oils, pancreatin and pepsin also require to be assayed. The revision committee has deemed it wise to admit quite a number of synthetic preparations, and it behooves us to familiarize ourselves with their official titles for more than one reason.

Frequently we prescribe a remedy under its commercial name, and our patient, finding it of value and knowing its name, dispenses with our advice and obtains it himself from the druggist. Can we blame the pharmacist for supplying it? Not at all. We ourselves are at fault. These synthetics when bought under a patented title cost many times more than they would when bought under the official name, and again there exists upon the market to-day a great number of preparations which are identical, but described under fanciful names. By demanding United States Pharmacopeia preparations you are assured of a product of uniform high quality, and you also aid to reduce the multiplicity of names, which must naturally produce confusion.

The following are the new synthetics with official titles, English names, and synonyms by which they are commonly known:

Acetphenetidinum, Acetphenetidin (*Phenacetin*).
Aethylis Carbamas, Ethyl Carbamate (*Urethane*).
Antipyrina (*Antipyrine*).
Benzo-sulphinidum, Benzo Sulphinide (*Saccharin*).

Chloral formamidum (*Chloral formamide*).

Guaiacol (*Guaiacol*).

Guaiacolis Carbonas (*Guaiacol Carbonate*).

Hexamethylenamina (*Hexamethylenamin*). (This is sold principally as *Urotropin*, also known as *Cystogen*, Formin, Ammonio Formaldehyde, Cystamine, etc.)

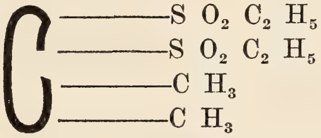
Iodolum (*Iodol*).

Methylthioninæ Hydrochloridum, Methylthionine Hydrochloride (*Methylene Blue*).

Sulphonethylmethanum, Sulphonethylmethane (*Trional*).

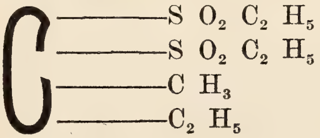
Sulphonmethanum, Sulphonmethane (*Sulphonal*).

I would call your special attention to the two above compounds and show wherein the difference lies. Let us regard these compounds as methane $C\ H_4$. In sulphonal two of its hydrogens have been reduced by the radical ethylsulphone ($C_2\ H_3$—$S\ O_2$) and the other two by the radical methyl ($C\ H_3$), which will give us the following formula:



$$\mathrm{C}\begin{cases}\text{———}\mathrm{S\ O_2\ C_2\ H_5}\\ \text{———}\mathrm{S\ O_2\ C_2\ H_5}\\ \text{———}\mathrm{C\ H_3}\\ \text{———}\mathrm{C\ H_3}\end{cases}$$

In trional, instead of the two hydrogens having been replaced by methyl, we find that but one has, and the other by ethyl ($C_2\ H_5$), giving us the following formula:



$$\mathrm{C}\begin{cases}\text{———}\mathrm{S\ O_2\ C_2\ H_5}\\ \text{———}\mathrm{S\ O_2\ C_2\ H_5}\\ \text{———}\mathrm{C\ H_3}\\ \text{———}\mathrm{C_2\ H_5}\end{cases}$$

We observe the difference between them is that sulphonal is a dimethyl, whereas trional is a methyl ethyl compound, and hence the difference in the official title.

Thymolis iodidum, thymol iodide (*Aristol*).

A few of the popular preparations with which the drug market has been flooded have been introduced under the following official titles:

Bismuthi subgallas, bismuth subgallate, in place of *dermatol*.

Cataplasma kaolini, cataplasm of kaolin to replace the muchly advertised *Antiphlogistin*.

Liquor antisepticus, antiseptic solution, to replace a host of similar remedies, foremost of which may be mentioned *Listerine.*

Liquor cresolis compositus, compound solution of cresol; this is a much needed addition for such preparations as *creolin, lysol, lysitol, kresol, etc.*

Liquor formaldehyde, solution of formaldehyde, also known as *formalin, formal* and *methaldehyde.*

Liquor sodii phosphatis compositus, compound solution of sodium phosphate. This solution contains 1 gram of sodium phosphate to each *c. c.* Pilulæ laxativæ compositæ (Compound Laxative Pills). Each pill contains aloin, 1-5 grain; strychnin, 1-140 gr.; ext. belladonna, 1-8 grain, and ipecac, 1-16 grain.

Pulvis acetanilidi compositus (Compound acetanilide powder). A combination of acetanilide, caffein and sodium bicarbonate so frequently found in the numerous "Magic" headache remedies.

Syrupus hypophosphitum compositus (Compound Syrup of Hypophosphites). This contains, besides the five hypophosphites, quinin and strychnin, and must not be confounded with syrupus hypophosphitum, which only contains the hypophosphites of calcium, sodium and potassium.

With but few exceptions common names have been discarded from the text; they will be found, however, in the index. This has been done in the hope that the physician and pharmacist will use only the Latin or English titles and soon these synonyms will finally become extinct.

To maintain greater uniformity as well as to conform to modern chemical nomenclature, the official titles of a few substances have been changed. Acidum arsenosum is now arsenii trioxidum; acidum chromicum to chromii trioxidum; chloral is changed to chloralum hydratum; acidum carbolicum to phenol; salol to phenylis salicylas; sodii sulphocarbolas to sodii phenol sulphonas; sodii hyposulphis to sodii thiosulphas.

A feature worthy of our attention is dosage. This, however, is not the first time it had been admitted into the pharmacopeia, as the first revision also contained this. These doses are only the average dose and it is distinctly stated "that neither the convention, nor the committee of revision created by it, intends to have these doses regarded as obligatory on the physician, or as forbidding him to exceed them whenever, in his judgment, this seems advisable."

Those who have had occasion to examine them know from practical knowledge they can be given in quantities far in excess of those given under the various substances. All arsenical preparations are as in the old pharmacopeia, 1%.

Serum therapy has one preparation official in serum antidipthericum. Animal materia medica has had two additions in glandulæ suprarenales siccæ (dessicated superarenal glands), and glandulæ thyroidcæ siccæ (Dessicated thyroid glands).

Tincture of iodin now contains, in addition to the iodin, 5% of potassium iodide. There may be two reasons for adding the same; first, the tincture as now prepared can be added to water without precipitation, and, second, it may prevent the decomposition which occurred in the old.

Since writing I have been informed that the Orleans Pharmaceutical Association has sent to each physician and pharmacist a card calling attention to the changes in strength of potent tinctures.

In closing, I would suggest that this Society send to each doctor and druggist of this city a notice to this effect:

That, for all prescriptions calling for official preparations, the Eighth Decenial Revision (1900) standard shall be dispensed unless otherwise specified.

MEETING OF OCTOBER 14, 1905.

DR. E. P. LOWE read a paper on:

"The Necessity for National Quarantine."

In presenting this paper I shall not weary you with a lengthy dissertation on the subject of National Quarantine, but shall present the arguments herein contained in a brief and concise form, amplifying only where it is necessary to emphasize their cogency. And just here I trust you will indulge me in a brief digression. In the incipiency of these remarks I wish to disavow any desire or inclination to cast aspersion upon the personnel of our boards of health. I desire to censure no one. I believe, when censuring one's conduct, to be just, we should first ascertain the character of the motive; and finding this unsullied, we should approach his chastisement with great charity. I desire merely to present now to your minds facts you are already familiar with, and to direct to them your thought and reflection, believing that you will take that action upon them which your judgment and the exigency of the situation require.

Repeatedly during the life of the nation, the foreign diseases, yellow fever, Asiatic cholera, and bubonic plague, and particularly the two former, having been brought to our shores through the usual channels of commerce, have decimated the population of our maritime cities, and brought uncalculated thousands of our citizens to grief and financial disaster. In the old days these visitations were attributed to the punitive acts of an outraged Providence, and hence were to be avoided in the future by prayer and religious devotion. But even then there were stout souls who had the temerity to cast doubt upon this doctrine. These savants declared that man himself was the author of his own punishment by ignoring the laws of health in accordance with which nature intended he should conform his life. Many theories were from time to time advanced as regards the essential cause of these pestilences, the last being the germ theory, which is now the accepted doctrine.

Yellow fever on an average of every eight years, for a period of more than sixty years, has devastated the Gulf Coast of our country. These visitations, which have in every instance been imported, have carried off thousands of our people, restricted foreign trade, paralyzed interstate commerce, and have caused such panic and mental confusion among our people as to have become intolerable. The profits earned by the industry and frugality of our people during the seven years of relief, have been swept away by the eighth year's epidemic. Neighbor has been cast against neighbor; friend against friend; men against the law; and law against law. Universal confusion of the popular mind has resulted in distorted judgment, and this in turn has begotten insane action. No man's legal rights are safe, except around his own abode, and he dares not venture far therefrom, for fear of a shotgun in the possession of an irresponsible quarantine guard—irresponsible, because frenzy has unbalanced the guard, and danger lurks in the pathway of the unfortunate who has the temerity to oppose him. City shuts out city, parish closes the door against parish, State ignores the rights of State, and even the rights of the General Government are intrenched on, and in some instances set at defiance. Health boards are in continual clash and conflict, inferior boards defying the mandates of their superiors. This condition of affairs befits the middle ages, but has no place in the civilization of the twentieth century. All efforts in the past on the part of the State, parish and municipal boards of health, to prevent the importation of foreign diseases, and to stamp them out when imported, have singularly failed. History proves this assertion. During every visitation of yellow fever we have been promised future immunity; but the disease recurs with singular regularity.

In searching for a cause of this failure on the part of the constituted health authorities, we naturally turn to an analysis of the authorities themselves. A careful analysis of the various organized health boards will disclose the following causes:

First: These boards are nearly all political, and are, of course, largely controlled by political considerations. If occasionally we find a board which has the robust courage to withstand political pressure, the public is fortunate indeed; for this is by no means the rule. Under such circumstances one need not be a seer to foretell failure.

Second: The limited power conferred upon these health authorities by the various legislative bodies concerned does not enable them to meet the situation with vigor and decision.

Thirdly: The various State, parish and municipal quarantine regulations result in conflict and confusion, frequently arraying the people of different States and even the people of the same State in hostile attitude toward each other if not in actual conflict.

Fourth: Being weak legally, these boards fail to secure the confidence and respect of the public, which are absolutely necessary to a successful conflict with epidemic diseases. The nearer the public approaches the source of law the less regard it has for it. Considerations of friendship for, and acquaintance with, the personnel of legislative bodies begets a spirit of favoritism which soon brings contempt for the law on the part of both the favored and the unfavored. Health authorities constitute no exception to the rule.

Fifth: Being local boards and deriving their support largely from local sources, they are liable to be influenced to a great extent by local commercial interest, thus weakening the efficiency of quarantine.

Sixth: The officers of these boards, being for the most part poorly paid, give a large share of their time to private affairs which should be devoted to the public service.

Seventh: The moneys placed at the disposal of the boards are not sufficient to permit them to employ competent aid in their struggle against disease. They are thus compelled to employ crude and untrained material who are only too frequently completely out of sympathy with the work of the board which employs them.

Eighth: A multiplicity of authorities means a division of responsibility, which cannot redound to the best interest of the health service.

Ninth: Present quarantine methods, by blocking the usual avenues of intercourse, force communication through other and surreptitious ways, thus inviting the smuggling of persons from one city or State into another, and thus defeating the purpose of quarantine.

Tenth: The health boards fail to obtain the co-operation of the physician in the beginning of the outbreak. The physician, under existing conditions, hesitates to report the first suspicious case of fever. He objects to bringing down upon the community panic and chaos. He is fully aware that his report of such a suspicious case must become a part of the health board's records, and therefore subject to public inspection; that, upon his report becoming publicly known, panic at once seizes the popular mind, and disarrangement of business and social conditions at once supervene.

But, suppose he does report his first case of suspicious fever, woe to him should the case prove a simple fever. The finger of censure and contempt will be forever pointed at him, and he loses caste with the community at large, if not also with his profession. The physician, therefore, only exercises extreme caution in not reporting his first suspicious case of fever; and so long as present methods predominate, and so long as self-interest continues to be the mainspring of human action, no different course can be reasonably expected of him. I do not refer here to well defined cases of yellow fever, which all conscientious physicians must report, but to those suspicious cases of fever which come under the observation of the physician just previous to an outbreak, a prompt report of which is so important to the board in its first days struggle with an epidemic.

Eleventh: The heterogeneous nature of our population, which increases rather than decreases under our present immigration laws, renders it impossible to unite the people in a harmonious action for any purpose. This assertion needs no proof. Witness the present opposition in all directions to the health authorities in their endeavors to stamp out the prevailing malady. Aspersion and contempt are heaped upon their well-meant and well-directed measures in the public defense. Doubt and antagonism are everywhere met with. In the words of a well-known American publicist, it is a condition, not a theory, which confronts us.

Contemplation of the foregoing facts will, I believe, bring conviction to the minds of the majority of our people that present methods of managing epidemic diseases is fallacious, futile and deceptive, and that other and better methods must be used before the much-desired relief is secured. To what safer authority can appeal be made than to the General Government. I advocate a National Quarantine law for the following reasons:

1. Because it is a government function and duty. It cannot be reasonably affirmed that yellow fever in New Orleans concerns New Orleans and the State of Louisiana alone; or that Asiatic cholera in New York is of interest to the City and State of New York alone; or that bubonic plague in San Francisco, appertains solely to San Francisco and the State of California. The States, counties and municipalities are so indissolubly bound together by the ties of common interest that it is impossible for foreign pestilence to prevail in one section of the Union without becoming a matter of national concern. Its prevention and elimination, therefore, become the national public duty. It has been alleged by some that such a law would be illegal since no such power is expressed in the National Constitution. It is inconceivable that the framers of the Constitution could have foreseen every possible emergency that might arise in the future path of the nation, and it is equally inconceivable that a body of wise lawgivers would fail to make some provision to meet such emergencies. I believe such provision to have been made. The phase, "general welfare," pointed out in the preamble, and occurring in the body of the Constitution among the enumerated powers of Congress, contains all possible implied powers required to provide for the wellbeing of the people; and

certainly the health of the people has much to do with their welfare. Again Congress has power to regulate foreign and interstate commerce, and in this power will be found ample authority to combat epidemic disease. Again in the term "national defense" implies national protection, it is difficult to understand why the General Government should not protect us against one destructive power as well as another. It has also been claimed that such a law would infringe State rights. To the States are reserved all power concerned in their internal government, but all authority concerned in interstate and national affairs is delegated forever to the General Government, and cannot be alienated therefrom except by a successful revolution against it.

2. Federal control of quarantine will, I believe, insure better results. By amplifying the present law, creating the Public Health and Marine Hospital Service, an army of trained men can be established and placed under the control and direction of expert sanitarians, such as are now engaged in that service. This army of trained disease fighters, clothed with full authority, could be transported speedily to any port invaded by disease, and there proceed to stamp out the infection.

3. Government control will restore full confidence among all of the people. This argument is fully answered by the facts of history. Instance the invasion of San Francisco, by bubonic plague, when the Federal Government was called upon to take control of the situation, with what results we all know; also instance the present visitation of yellow fever in this city. In fact, wherever a great epidemic has occurred or threatened, the General Government has been asked to aid, thus proving the people themselves have full confidence in the government management.

4. The functions of government as pertaining to the postal service, interstate commerce, and the general welfare will not be impeded.

5. The experience and trained observations of expert sanitarians, who, under ample salaries, devote all their time and talent to the study of national health conditions, will surely add to scientific knowledge and achievement, which will become the heritage not only of our own nation, but of all the world. Stimulated by the spirit of investigation, these sanitarians will push forward with their

experiments and observations, until their labors are rewarded by further discoveries in the field of etiology and treatment of disease; thus resulting in better health conditions of the people.

6. Federal control will keep open the avenues of trade and commerce with equal justice to all. With the management of yellow fever, bubonic plague and Asiatic cholera entirely in Federal control, the mutual distrust and conflicting action of cities, parishes and States will forever disappear, and in their wake will follow mutual respect and confidence, finally unfolding into a broader and more durable prosperity—thus enhancing the happiness of all the people and the glory of the nation. It then becomes impossible for rival commercial cities, by influencing unjustly quarantine regulations, to bring pestilential disaster upon themselves or their neighbors.

I do not wish to be understood as advocating the abolition of our present boards of health. Every civilized community requires their services to prevent the propagation and spread of the usual endemic diseases, and to enforce general sanitary regulations. But we need a strong power to stand guard against pestilence in its foreign habitat to prevent its embarkation on ships bound for our shores; and, should it evade this inspection, we need a strong power to intercept it on the high seas to prevent its debarkation; but should it also escape this vigilance, we need a strong power to strangle it when it lands. Already there are indications that the great entity, the public, is changing its mind on matters of quarantine. Upon every side can be heard the mutterings of discontent. The handwriting is on the wall. The finger of fate is pointed at the death of present conditions. Will the medical profession of New Orleans assist in this great movement for the betterment of these conditions, or will it prove recreant to its obligations? Will it help propel the wheels of progress, or will it suffer itself to be dragged along by their irresistible whirl? I appeal to you in the interest of the city, on behalf of the South and the whole country, to exert your earnest and best endeavors to the end that a competent quarantine law may be placed upon the statute books at Washington, which will cast its beneficent effects, not only upon the South, but the entire nation. Under the far-reaching influence of such a law, our people, feeling a sense of security, hitherto unknown to them, will redouble their energies in the great task of developing our resources and evolving our civilization. Every section of the nation will feel the impulse of a new life. Our beloved, though stricken South will lift again her prostrate form, and garbed, not in the vesture of war, but in the habiliments of peace, will go forth again to conflict and snatch at last from frequent pestilential defeat the flower of victory; while New Orleans, the prophetic city by the Mexican Sea, though often cast down, will rise to loftier heights of splendor and ultimately reach the full fruition of her great destiny.

MEETING OF OCTOBER 28, 1905.

DR. GORDON KING read a paper on:

"A Lymphoid Tumor of the Larynx Removed by Partial Laryngectomy."

Mr. O———, a native of New Orleans, 65 years of age, came to consult me on July 3 on account of hoarseness and dyspnea. Heredity history excellent, both his parents and grandparents having lived to ripe old age. Had one sister to die of tuberculosis, family history otherwise good. He had been a constant and excessive smoker since the age of 18 years, was not addicted to alcohol at any time, nor had been in any wise unhealthy until about two years ago. At that time a succession of severe colds contracted while pursuing his occupation of traveling salesman finally left him with a hoarseness which has been persistent for the past year. His general health seemed in no wise affected, and no treatment was sought for relief of the local trouble. In the month of May he began to experience some night attacks of dyspnea and a constant shortness of breath which had steadily grown worse until, at the time I first saw him, the slightest exertion gave rise to great embarrassment of respiration. Though somewhat thin and weak from lack of rest at night, he seemed otherwise to be in good condition. Laryngoscopic examination revealed two smooth rounded tumefactions on the left side of the larynx involving the base of the epiglottis and the entire inner surface of the thyroid plate. Vocal movement was abolished on that side and the glottis almost occluded by the growth. The tumor appeared to be entirely intrinsic and no involvement of glands could be detected. There was no ulceration, edema or other evidence of inflammatory disturbance present in the larynx, the tumor being covered with normal mucous membrane. As the increasing dyspnea demanded first attention, a low tracheotomy was performed under cocain anesthesia July 4th and a tube inserted. Ten days later, with the assistance of Drs. Friedrichs, Bird and Crawford, I removed the left half of the larynx with the tumor attached, as can be seen by the specimen presented. The thyroid cartilage was seen to be infiltrated at one point near the commissure, otherwise there was no invasion of the external parts. The laryngeal cavity, after being packed with gauze, was closed with deep sutres with the exception of a small opening left for drainage at the lower angle of the wound above the tracheotomy tube. Within forty-eight hours the patient was able to take liquid nourishment by mouth and made a rapid convalescence. After closure of the tracheal opening the voice was restored to as good a tone as he had before the operation. About the first of October some respiratory stridor had again become apparent caused by a tumefaction which could be seen with the laryngoscope in the subglottic region near the median line. This I took to be a beginning recurrence of the tumor, which in the meantime had been examined by Dr. Pothier and pronounced to be of lymphoid structure. The larynx was accordingly opened again in the old line of incision, and the tumefaction seen from above was cut away, together with a part of the thyroid cartilage at that point. I refrained from removing the entire right thyroid for the reason that the tumefaction appeared upon close inspection to be more like cicatrical tissue than recurrent growth. The patient at present is at his place of business again and the tracheotomy opening nearly closed. As yet there is no sign of returning growth, but of course it is too early to predict the ultimate result.

DR. GORDON KING also read a paper on:

"A Voluminous Papilloma of the Nasal Cavity."

The patient from whom this rather unusual neoplasm was removed is a negro woman 48 years of age, who came to the clinic of the Eye, Ear, Nose and Throat Hospital in June of this year, and gave the following history of her case:

About fifteen years ago her attention was drawn to the fact that the left side of her nose was becoming obstructed and comfort in breathing considerably compromised. A physician was consulted, who discovered a growth in the nasal fossa and promptly removed it, the tumor being described by the patient as a polypus. Relief was obtained for a period of two years, when a recurrence of the stenosis took place, but the patient did not seek medical advice again until five years later, when a second tumor apparently of similar nature was removed from the nose. About four years ago, according to the patient, Dr. Johnson of Bayou Tunica, treated her for the same symptoms and afforded her much relief by extracting several tumors or fragments of a tumor from the same side of the nose. At that time there was a noticeable swelling on the left side of the nose externally near the inner angle of the orbit, and some pain was experienced in this region. In spite of these repeated interventions the nasal stenosis came on again, with a gradual increase in the facial swelling and the pressure pains during the past three years.

When examined at the clinic upon her entrance there the patient showed a final facial deformity quite characteristic of an intranasal neoplasm—in fact, the typical frog face with the swelling more apparent on the left side. A soft, whitish, fibrilated growth was seen protruding at the anterior naris, displacing the septum completely to the right, filling the left nasal fossa, and giving rise to some exopthalmos on that side.

Posteriorly a mass of considerable dimensions hung into the nasopharynx and interfered with the palatal movements.

Extirpation being decided upon, the bulk of the growth was removed without difficulty by means of the snare and scissors, and quite a free hemorrhage occurred when the base was cut through. This was checked by compression with tampons, and later the remaining fragments were removed by cutting forceps. The tumor was found to be attached to the middle turbinate and the ethmoidal region by a rather broad base, encroaching in its development upon the antrum and the orbit and dilating the nasal cavity widely. Examined microscopically at the New Orleans Clinical Laboratory the growth was shown to be a cylindrical papilloma, which the clinical history and miscroscopical appearance indicated, although from its extensive development malignancy was feared.

Realizing the likelihood of an early recurrence, I endeavored to persuade the patient to remain under observation that it might be attacked promptly and ultimately eradicated, but as she lived at a distance from the city and was unwilling to remain, the subsequent behavior of the case cannot at present be recorded.

The chief feature of interest in this case lies in the fact that true papillomata are comparatively rare in the nasal cavity, and when they do exist are usually of very small size, pedunculated, and often accompany the development of polypi or other growths. Literature furnishes but few records even of such cases, and only two can I find that showed the same tendency to large development and deformation of the nose.

One of these was reported by Verneuil in 1884, and the other by Aysaguer in 1885. Verneuil's case required resection of the anterior antral wall, and repeated operations for recurrence, and exhibited certain malignant features, such as were observed in the case I record.

The microscopical examination is very necessary for a positive diagnosis in these cases, especially when the tumors of the nasal fossæ sometimes present a papillomatous aspect to the naked eye and yet show a very different histological structure. The only effective treatment is complete extirpation.

DR. E. DENEGRE MARTIN read a paper entitled:

"Abuses Arising from Thoughtlessly Issuing Certificates of Accident to Injured Parties and Over Charges for Professional Services Rendered when Corporations are Liable."

Any physician who has had to look after the interest of a large corporation knows full well the abuses practiced by professional men, both in regard to testimony and charges for professional services rendered. As a rule the injured parties belong to the laboring class and are frequently attended by their society doctor, who is often too busy to make a careful examination, or totally ignorant of surgical conditions, and issues a certificate which is anything but clear as to facts. In a large percentage of cases the patient is infected by careless dressing and convalescence is greatly prolonged. As a rule some lawyer is employed on a contingent fee to prosecute the case. In the petition we read of the long illness and great suffering of the patient, which impresses the jury, and a verdict always in favor of the plaintiff is rendered. All the experts in the country could not prove that the case had been improperly treated, and it is for this reason that corporations much prefer to pay a large compromise than stand suit. On one occasion a woman, riding on a street car, saw a freight car approaching, and believeing it would run down the car in which she sat jumped from the moving car and landed in a heap of freshly removed gutter mud. Her feelings were undoubtedly hurt and a petition from her lawyer cited some physical injuries. The certificate of the attending physician stated that she had sustained a prolapsus uteri. On examining this woman I learned that she had been attended by nine physicians for uterine trouble prior to her fall. Her statement I was willing to accept, for the evidences of trouble still remained. Her lawyer entered suit for $10,000 damages. When the physician realized that he would be called upon to testify and that his diagnosis would be questioned, he very kindly used his influence in compromising this suit, which was settled for $750. Be it said to his credit, he issued the certificate not knowing that it would be used in a suit against the railroad, but rather to indicate that she had some trouble for which she was being treated, and upon which she could claim relief from her society.

On another occasion a woman weighing two hundred pounds, while riding in an open street car, was thrown from the seat and fell to the ground. She was pretty seriously shaken up, but very slightly injured. A physician was called to see her and certified that she had a few bruises about the left side, and was menstruating at the time. This statement was not satisfactory to the parties concerned and furnished a small basis for suit. Another physician, but not of our persuasion I am glad to say, was summoned, and for the consideration of two hundred dollars, discovered an incomplete fracture of the *anterior inferior spine of the ilium* on the left side. This woman had been offered one thousand dollars in settlement of her claim. She was advised by her attorney to bring suit. After the trial, during which I was kept on the witness stand the entire day, and used as a medium of demonstrating to the judge and jury the great fund of medical knowledge possessed by the attorney, the jury rendered a verdict for $1,200, two hundred for the doctor, according to agreement, five hundred for the lawyer and the remaining five hundred for the injured party. I might cite a number of just such cases, but these I trust will be sufficient to illustrate the character and worth of certificates often issued. But it is not alone in the issuing of certificates that the greatest abuse is manifest. It is most interesting in reading the petitions of the plaintiffs to learn of the terrible injuries they sustained, the suffering they endured and the expense incurred in treatment. I refer not to serious injuries, for those usually go to the hospitals, or get into the hands of competent men, but rather cases of slight injuries, when life is not involved, and when nothing can prevent the patient from recovering. Several years ago an employee of a railroad fell and sprained his back. I saw him shortly after the accident. The injury was slight and I so reported. My visit was not satisfactory and another physician was called. Two months later the company received a bill for surgical services amounting to $200 and a bill for drugs for $75. I settled the doctor's claim for $50, and the drug bill for $25. The assumption in this case was that the road was rich and must be made to pay. On another occasion a boy twelve years of age was burned on the left arm by a live telephone wire. The burn was deep, partly severing the carpo-flexor-ulnaris, making rather an ugly wound, but not extensive and required simple dressing. Professional services in this case amounted to $1,050. Fifty dollars would not have been too small a fee in this case and one hundred would have been a maximum fee. It is not infrequently the case that bills for $20 are rendered for one or two visits and paid because the cost of fighting these cases in the courts are ruinous, for it must be recollected that these are matters of almost daily occurrence. I have several cases under consideration at present which will probably go to the courts as the compromise asked is out of all proportion to the injuries sustained. It is the most singular thing that parents who have been cruel to their children are suddenly seized with remorse of conscience when one of their children meets with an accident and the demand for the mental anguish they suffer often reaches into the thousands. That corporations should pay the maximum fee for services rendered is just and right, but why should they, more than wealthy individuals, be forced to settle claims which are nothing short of extortion, I fear physicians are often too lax in issuing certificates, not only for injury, but even for minor matters. A patient, a busy man, is called upon to serve on the jury. He comes to his physician for help and often goes to court with a certificate of disability, for which he pays nothing, or, at the most, one dollar. He is enabled by practicing this fraud to make many hundreds. Not long ago a patient, the cashier in a hotel, came to me saying that she and another young lady were witnesses against a man who had passed a bogus check and that she would have to appear that day in court, that the other girl had got a certificate from her doctor stating that she was ill and that she would like to have one also. Before leaving my office I succeeded in persuading her to go to court, which she did. While these certificates are inoffensive little slips of paper apparently of no value, yet how often are they used by unprincipled lawyers to further an end and our profession is stultified by its own members. It is a well known fact that there are physicians in this town who will falsely fill applications for civil service positions. So far as I know they are not members of this association, and I hope will never be. I have called your attention to these abuses to-night because I am frequently called upon to pass on the claims of physicians, and in many instances they are beyond all reason; making the task anything but a pleasant one for me.

MEETING OF NOVEMBER 11, 1905.

Dr. C. M. Brady read a paper on:

"The Prevalence and Diagnosis of Yellow Fever in the Colored Race."

At the request of the President of this Society I desire to bring out some salient points as to the prevalence and diagnosis of yellow fever among negroes.

1st. Prevalence. It is as positively, and I believe, more commonly, contracted by negroes than by whites in the country communities where I have worked this year; for the following reasons:

They have little dread of contracting any disease. What will be will be is their fatalistic belief and they are particularly fearless of contracting yellow fever, thinking it is a white man's disease, and they are not subject to it. This belief is unfortunately somewhat common among the whites, even with some old-school physicians.

Negroes less frequently use protection against the mosquito than whites, or use such an inferior quality of netting that they become a prey to the insect, infected or otherwise.

Even the slightest acquaintances will visit the sick, not to mention friends and relatives. We know how the occurrence of a funeral is taken advantage of as a meeting place, where, like the Italians, they will gather around the corpse in numbers, fight infected stegomyiæ, if present, or let them bite at liberty in their devotion.

When yellow fever first occurs in a community among the whites, the negroes are soon infected through housemaids, washerwomen and cooks. The unusual prevalence among the people during 1905 was due to the fever's appearing first among the Italians in New Orleans, many of whom scattered to the plantations. Here they soon infected the laborers' quarters, first of their own people, then of the negroes, who, as I have just said, are great visitors of the sick and besides associate with the Italians on certain terms of social equality.

A second atrium of infection lies in the custom of Italian fruit vendors to have a staff of several negro boy hangers-on, who promptly contract the disease from their masters and return to their respective homes with the usual consequences. A white man travels by public and private conveyance along public highways in the daytime, and makes few attempts to evade the law, consequently his movements are reasonably safe. As a rule he cares too much for his family to willfully visit an infected community.

The negro is a night traveler on foot, by short cuts and byepaths. He sees the fire of the quarantine guard and makes a circle around his camp, or his bye-path leads him by a direct route, safe from observation. A negro will not hesitate to walk ten or fifteen miles at night to see his lady love in an infected house, pass half a dozen quarantine guards, and get back to work before daybreak as if he had not stirred from home. When he gets the fever he is perfectly aware of its nature and avoids the doctor with the same care with which he should have avoided the fever. In due time when he is well and perhaps strenuously claims to have never been sick, several members of his family or some friends whose home he has visited when feeling bad are taken sick. It is a mental characteristic of the negroes that they try to escape a fever or severe pain by leaving their homes. If a doctor sees these cases, perhaps children, who have never stirred from their home, even if he suspects yellow fever, he hesitates to make a diagnosis. There is no way of tracing an infection and it is a difficult matter in children anyway so it goes on to the third or fourth infection before the nature of the fever is discovered. Proof of the correctness of my statements is to be found in the condition at Tallulah, Lake Providence, Bon Ami, the Terrebonne Plantations, and others where the number of cases among the colored outnumber the white cases 8 or 9 to 1, even including the Italians, who first brought the disease to these points.

DIAGNOSIS.

Temperature—There is the same range of temperature in one race as in the other, except that the negroes are apt to have the secondary rise not so elevated nor so pronounced.

Pulse—During the initial stage the pulse averages the same in both races, but in convalescence it is decidely lower in the black than in the white race as a class, and the number of individuals with a low pulse is greater. This is a valuable diagnostic point. I have seen a family recovered from a high fever, of whom two members had died of supposed typhoid, each one attending to his or her usual duties with a pulse between 45 and 55. I may mention incidentally that these cases had other marked symptoms of yellow fever. To that family was traced directly a death in the third infection.

Albumen—There is less albumen and more often none at all among cases in the race under discussion.

Jaundice—It is difficult to detect jaundice of the skin in the colored race uness very pronounced, and that is unusual.

Capillary Stasis—This is present but hard to detect and should not be taken into consideration. The whole cutaneous surface when severe resembles the part where a mustard plaster has been used—an ashy grayish, bleached appearance.

Eye—The eye in the negro is often normally injected, but in yellow fever the injection is remarkable and much more pronounced than in the white person suffering with a case of the same degree of severity. In due time the usual jaundice is detected, but care must be taken not to mistake the normal yellow fat which shows very plainly in some individuals.

Gums—When one finds the swollen, spongy gums of yellow fever in the negro, there is little need to make allowances for decayed teeth or salivation. The teeth usually are good. The gums and tongue with a tendency to bleed, a red hyperemic mouth and fauces, the swollen lips, with the black face as a background, make a characteristic picture and one that should not be mistaken.

Prostration—Prostration in my opinion lasts as long in the negroes as in the whites. A white patient takes more care of himself in convalescence; a negro does not. He is gregarious and staggers out to where he can get company. After recovery from an attack of the same degree of severity they are not able to return to work as quickly as the white.

DEATH RATE.

It is a well known fact that the death rate of yellow fever among the negroes is decidedly lower than that of the Caucasian race, even excluding the Italians, who practically commit suicide in their fear and ignorance. I estimate about 1 negro death to 5 or 6 native born whites. In all other diseases the negro mortality is about double the white. In yellow fever alone he has the advantage. What peculiarity of this race is it that conduces to such an advantage in their yellow fever death rate? It is not true that an immunity to the disease has been inherited from a long line of African ancestors, and that the disease was brought to America in slave-ships. It is thought Columbus lost many of his crew from yellow fever on one of his voyages.

Then why is it so and what is the reason for their low death rate?

We know that they have less albumen during the attack and a lower range of pulse in convalescence. Less albumen means less mixed infection, less auto-intoxication.

The pure toxins of yellow fever slow the pulse, the mixed infection increases it. One at once sees that there is more influence of the direct toxins of yellow fever and less of the mixed secondary toxins in the colored race.

We are all aware that death in yellow fever is rarely produced by the direct toxin of the disease, but is almost invariably due to the secondary infection as shown by increasing albumen, yellowing of skin and weakening of the pulse. This is the reason why the negro does not die in yellow fever. Why is it so, with their evil mode of life, manifest dissipation and carelessness of habits?

I shall attempt to answer these questions:

1st. They are fatalists, think nothing of yellow fever and do not worry; we know how serious it is to those who worry and are frightened of the disease.

2d. The sweat glands of the negro are decidedly more active than those of the white race; one sees them perspiring freely from very moderate exercise and can note by the odor of their bodies the constant elimination going on. They are great water drinkers, eat, coarse, rough food, and do not suffer from constipation to any extent. They have more regard for the regularity of their bowel movements than the whites. Thus they have free elimination with a calm mind. Their home treatment is ideal for yellow fever. This is carried on by the old negroe grannies and nurse women in fevers and diseases of any kind. It consists of purgatives, tisanes and free sweating. How often does a doctor hear when he reaches a negro cabin: "Doctor, I gave him a dose of castor oil and a good sweat." They continue giving teas and keep the patient well covered up and sweat him till the fever leaves.

This is the difference between the Italian and the negro: Both dodge the doctor; the Italian forces himself to eat, while the negro cannot be made to eat.

SUMMARY.

The low death rate of the negro race is due, I believe, to

1st. A phlegmatic temper.

2d. Active elimination from the sweat glands.

3d. The drinking of much fluid in the form of tisanes.

4th. Regular bowel movements.

5th. Refusal to eat when sick.

DR. BRADY also read a paper on:

Diagnosis of Mild Yellow Fever and Some of Its Difficulties.

The symptomatology and general characteristics of a typical case of yellow fever are so well understood and appreciated by the average practitioner of medicine in this section that it is fruitless labor to more than call attention to them. Severe headache, loin pains, backache, muscular pains of the extremities, a congested face, flushed and swollen, injected, glistening, shining eyes, jaundice after a few days, congested, spongy and hemorrhagic gums, narrow tongue coated, in the middle, with red edges and tips, with a tendency to bleed; skin of yellow color, increasing from day to day; pulse falling for three days, then dropping below normal in convalescene to as low as forty, soft and compressible; scanty albuminous urine, and lastly black vomit, bleeding from mucous membrane anywhere, suppression of urine, uræmic coma and convulsions—often with dusky cyanosed skin, making till after death the saffron hue, which then appears.

It is to the mild cases I wish to call your attention. A case possibly never going to bed at all, or only in the stage of secondary rise of temperature, when some imprudence has accentuated the attack, and made known to the doctor and family that they have on hand a case of yellow fever. Such cases in children, among whom the death rate is one in two hundred, I would rather treat than measles.

Be especially guarded in any group of cases of the same type occurring either simultaneously or in succession in the same family or immediate neighborhood, evidently spreading from house to house—cases that last from twelve hours to three days, and are apparently influenced by quinin with marvelous ease, or recover just as well without it; fevers that show decidedly more prostration than one would expect, considering the readiness with which they seemingly yield to treatment. Watch with attentive eye any person who falls sick three to five days, and particularly three days after visiting a house of one who has recently recovered from sickness, or one who has gone into the house at a funeral where a person has died of typhoid fever, pernicious or hemorrhagic malaria, bilious remittent fever, acute nephritis, uræmia, acute parenchytous hepatitis or acute yellow atrophy of the liver. I have seen all these diagnoses given in undoubted yellow fever. Watch any case of a person dying with marked jaundice of short duration, with especial regard to the absence of ascites. In fine, cases that occur after visiting a house where there has been fever of any kind in summer and autumn. Do not forget to watch, in regions where yellow fever is possible, cases that develop in fifteen to eighteen days after some one from elsewhere has visited a family or a store.

The experience of Patterson and of Tallulah shows that the person who starts the infection in a locality may do by merely stopping a short while in a house or store to rest, without perhaps complaining while there of any malaise. Therefore, in tracing the seemingly mysterious origin of infection, always look for such a history of a passing stranger, who can often be traced by his becoming palpably sick at some other place. One such passing stranger infected Vicksburg, Tallulah and Lake Providence in succession. Calculate well the number of days of mosquito infection, twelve days and more, and add the three days average before the fever develops after the bite of the mosquito.

Be specially mindful of a chill at night, but do not depend upon it as positive. It may be typhoid or septic or even nervous. Mild cases frequently have no chill, or at most a sensation or creepiness about the body.

PAINS.

Pains even in the mildest cases are to be looked for, either in the head, back or limbs. Pains alone in the extremities are sometimes found not noticed elsewhere, unless brought out by questioning. Dr. Touatre lays special stress on pains in back, lumbar pains—a feeling that the back is breaking. I have seen two cases; one of which the attending physician assured me had severe headache with increased pulse and normal temperature some hours before the fever developed. The second had no temperature during the entire attack, but symptoms of yellow fever. Although constantly exposed he did not afterwards develop yellow fever. Cases of this kind are no doubt infectious, probably even for some hours previous to the headache.

PULSE.

In the beginning of an attack expect a rapid, full pulse, about in accordance with the temperature, falling in the great majority of cases or remaining stationary while temperature rises. This is not an invariable rule in very mild cases, but can generally be expected with confidence. I believe the failure to detect this is due for the most part to inattention or infrequent visits of the attending physician. Do not always look for a subnormal pulse. A temperature of 101 and a pulse of 80 is not infrequent in mild cases of yellow fever. The pulse in secondary rise of temperature, a condition due to toxemia and auto-intoxication increases steadily as the condition becomes graver, and when it climbs to 130 or 140 death is not far distant. The utmost care should be taken to distinguish this condition from malarial and typhoid fevers. It is partly a septic infection, a mixed toxemia, due, as I believe, to the failure of the liver to destroy the toxins produced in the blood and intestines—a typical auto-intoxication.

TEMPERATURE.

Mild yellow fever has a low range of temperature. Such cases sometimes do not range above 99½ (see report of Reed and Carroll) and rarely go above 102 degrees, unless momentarily. Moderate cases above 103 or 104 degrees.

A patient of mine had a temperature of 99½ degrees that lasted from 4 p. m. until morning; it was normal at 7 a. m., and there was no fever afterwards, but slight albumen on third day. He recovered, went back to work and took a relapse, had 35% albumen, temperature as high as 105 with uremic headaches and other accompanying symptoms, and died in five days. A child with fever lasting only six hours is the only known source of infection in his family fifteen days later.

Dr. Touatre reports a case taken sick thirty days after recovery from a severe attack with another severe attack, the two attacks lasting sixty days. In so-called ambulant cases, individuals with astonishing frequency go through an attack of fever without seeking the bed at all or at most are confined only a part of the day, aware of a feeling of malaise, but not deeming it of sufficient importance to warrant discontinuing their daily duties.

These, when they prove fatal, are reported often as cases which die suddenly, within one to two days after an attack of yellow fever.

I have notes of a case of a 14-year-old girl who cooked the daily meals of a family, eating with them. She cooked the supper one night and ate heartily, then went to bed, where she died two or three hours afterwards.

ALBUMEN.

Do not depend upon the invariable presence of albumen in the urine. The absence of albumen is no proof of the absence of yellow fever, nor is its presence the reverse. Thus the diagnosis of yellow fever does not exclude pre-existing chronic int. nephritis, nor the albuminuria of pregnancy. A chill and fever with albuminuria in considerable amount the first day and diminishing daily means probably only chronic interstitial nephritis with an acute malarial attack. Albumen beginning early in the disease on the first or second day means a very severe, probably fatal, case. The amount of urine secreted is more important than the percentage of albumen; less than sixteen ounces in twenty-four hours is dangerous. Children do not, as a rule, have albumen detected by the ordinary heat and nitric acid or the cold ring test, or have it for such a short period of time that the average practitioner does not catch it. Mild cases of yellow fever in adults nearly always have some albumen from the third to fifth day or on one of those days. Sometimes we do not detect albumen until the sixth day or later. This is for the most part due to a toxemia and auto-toxication in a case originally of a mild type, but altered through imprudence of diet or exercise.

Capillary stasis due to sluggish circulation is easily made out and in serious cases is found frequently pronounced when convalescence has far advanced. Pressure is better made with the extended fingers over the thorax. The same over extremities is not to be depended upon, as that condition of circulation is almost normal in some people.

GUMS.

Swollen and congested gums are usually found and often last far into convalescence. They are not hemorrhagic in mild cases, but capillary stasis is marked on pressure and when pressure is sharply made will frequently cause bleeding around the teeth. We must be careful to exclude the spongy gums of salivation and decayed teeth; taking the conditions of the gums in connection with other symptoms. The swollen upper lip is quite often noticeable, and taken with extremely rosy lips, especially children, it makes a very suggestive picture.

TONGUE.

Look for a small tongue, usually coated in the middle (but not invariably), with red edges and the tip at times almost of a strawberry type. The same condition of the tongue except broad strawberry, is seen in yellow fever in very malarial districts, which is diagnosed by other symptoms. The presence of the plasmodium does not contraindicate yellow fever.

STOMACH.

The patient in moderate cases usually complains of pains over the epigastrium, elicited easily on pressure, but practically absent when the attack is of a mild nature. While constant and uncontrollable vomiting is customary in severe cases, mild cases occur with slight gastric discomfort.

EYES.

Jaundice of the eyes should be discovered by the third day, but is often absent in cases such as those under discussion. The skin is not jaundiced in mild cases to any appreciable extent, and one must not hesitate to make a diagnosis where no jaundice ever occurred or where it was at most but slight and transient, and after the fever has gone. Finally be extremely wary in deciding the nature of a fever that occurs within the limits of a strict shotgun quarantine. The stricter the quarantine the more suspicious you should be. These places quarantine too late, are given false confidence, deem it impossible to have the fever, and it runs along in their midst with occasional deaths, concealed by some such medical heavyweight as acute parenchymatous hepatitis, till one or more become dangerously sick in the same house or die, and they suddenly become aware that an epidemic is prevalent. Even then some physicians will doubt it and honestly try to make themselves believe that this is the usual type of autumnal fever.

Especial attention should be paid to the efforts of towns as well as families to deny the presence of yellow fever. They cry out too clamorously; they protest before they are accused. The presence of yellow fever in a community seems to have a malign influence on some individuals. Efforts are continually made to deceive the physicians, even by those from whom one would least expect this. To do this we must be circumspect in weighing their statements if we do not wish to be deceived. I often compare some yellow fever cases with the victim of the drug habit.

Individuals sick with fever and believing that they have been exposed try to deceive themselves, force themselves to eat regularly, and go about their usual duties with a mild case until they are convalescent, or until they become so seriously sick that they collapse. In the meantime, during their first three days, they infect schools, churches, stores, the residences of their neighbors or their relatives, and in every way unconsciously do their best to spread the infection.

DR. ARTHUR NOLTE read a paper on:

"State Quarantine."

Before entering into the discussion of the subject of this paper I desire to make certain explanations of a personal nature. I disclaim any intention of reflecting personally upon any member of the Public Health and Marine Hospital Service, many of them are my personal friends; I only wish to criticise the official acts of the service to which they belong. I would also say that the opinions expressed, and the facts enumerated, do not emanate from me as a member of the Louisiana State Board of Health, but as a physician, a member of this Society, and a citizen of this State, who is unwilling to acknowledge that he is an imbecile, or lives in a community who are imbeciles and incapable of self-government, or of managing the affairs which concern this State.

Whenever a number of cases of yellow fever (that is the disease which chiefly concerns us at the present) occur in this State the resulting quarantines are so very disastrous that most people become wildly frantic and rush forth to seek remedies for the distress. This usually results in a change either of the personnel of the local or State Health Boards, or in the form of the Health Laws. At the present time there is great clamor among people, high and low, physicians and laymen, for what is called "National Control." Most of those who join in this clamor do not know what "National Control" means, or at least they have made no clear and definite explanation of what they mean. I shall take it that what is meant is that they wish the Federal Government in the form of the Public Health and Marine Hospital Service shall have additional powers to what it now has in health and quarantine matters of the State, and that the State shall be deprived in whole or in the greater part of its powers, rights, functions and duties in those matters as exercised up to the present time. That surely must be the meaning if there is any meaning. This call for "National Control," if it proceeds from a reasonable basis, must be founded on the belief that the Public Health and Marine Hospital Service is more competent and more efficient than any body of men which could be obtained in this State and that the results which it would get must be more beneficial to this State and would lessen the burdens and relieve the distress of the people in times of the presence of yellow fever. Let us therefore carefully consider whether such a belief is really justifiable.

The Public Health and Marine Hospital Service, or, as it was then known, the Marine Hospital Service, was established in reconstruction periods durings the Republican regime and its duties were to attend the sick of the merchant marine. These duties were chiefly exercised in this portion of the country in treating negro "roustabouts" on the Mississippi River steamboats, and a fee of ten cents weekly was collected from the wages of each one of these sailors or "roustabouts" to maintain the service. Medical men who entered this service were at times required to pass a not difficult examination, and some even obtained a position therein who were not graduates in medicine. The Army and Navy Medical Department did not consider those of the above service as entitled to full fellowship with them. After a while this entrance examination was made a little more severe (but it is now even not as difficult as that required of an applicant to the position of Interne of our Charity Hospital), and through the maintenance of a powerful lobby at Washington the powers and duties of the service were increased gradually until Congress passed the Act of July 1, 1903, and it blossomed forth as the Public Health and Marine Hospital Service, and the personnel thereof were given the rank and pay of the officers in the Army and were allowed to wear a somewhat similar uniform and a sword. The power of supervising all State quarantine was given to it. If in the opinion of the Surgeon General the quarantine as practiced by any State at any of its ports of entry is *not sufficient* to safeguard the country against importation of disease, he has the power to make it so. Any one enters the service as a first lieutenant, then in a few years he becomes captain, then major, and then lieutenant-colonel, which is the highest rank, I believe, with the exception of the one of surgeon-general. The pay ranges from $133 to about $300 per month. From these facts it could hardly be held that *ALL* the most capable and the most brilliant young men, especially from the South, would rush to join the service. I believe that some would remain to us who would care to enter private practice or State service.

As it is proposed to surrender all rights of quarantine to this branch of the Federal Government, let us look at some of their deeds in the past. Have they in the past prevented the invasion of pestilential disease? Have they been possessed of *all* the honesty and have they been free of the evil influence of corrupt politics as has been claimed by the author of a paper read to this Society some weeks ago, and have they acted with justice to and for the good of the South?

It is not a very difficult matter to show beyond the shadow of a doubt that yellow fever was introduced into this country through the inabilty or negligence of the Marine Hospital Service branch of the Federal Government. In August, 1893, yellow fever was actually brought into thetown of Brunswick, Ga., by the Marine Hospital Service, and the epidemic which resulted therefrom lasted until the end of November. The details of this introduction were so notorious that it is not necessary to go into them now.

In 1897 yellow fever first appeared in this country at Ocean Springs, Miss. The Treasury Department of the United States, through its two services, the Revenue Cutter and Marine Hospital Service Quarantine on Ship Island, permitted Cuban filibusters to make headquarters in Ocean Springs. Yellow fever was brought over by these filibusters through the lines of the Marine Hospital Service Quarantine at Ship Island to Ocean Springs and from there spread to New Orleans and Mobile.

In this recent outbreak of yellow fever, while it is impossible at present to trace the origin of the fever, yet it is highly probable that it came from Belize or Port Cortez through some of the ports of the Gulf States.

For the first time in years the Louisiana State Board of Health, at the request of the Mobile health authorities, did not put an inspector of its own at Belize or Port Cortez. They relied upon the officers of the Public Health and Marine Hosptal Service, so did Alabama and Texas. The Marine Hospital officer at Belize gave clean bills of health from that place from the beginning of the season, April 1 to the 24th of May, nearly two months, by which time yellow fever was epidemic in Belize. The same statement hold good for Port Cortez, also on the Honduras mail route.

In marked contrast to the above was the action of the Louisiana State Board of Health's inspector, Dr. W. H. Woods, who in July of 1900, discovered the first case of yellow fever in Limon, and cabled the fact to the Board, although his diagnosis was strongly opposed by two Marine Hospital Service men and two local physicians. The sequel proved that Dr. Woods was correct.

Early in the year 1900 bubonic plague appeared in San Francisco. A few cases were reported to the public from time to time at long intervals, and then it was claimed by the authorities, many people, merchants, railroad companies, of California, that the disease had been stamped out. Clean bills of health were issued by the Marine Hospital Service from that port. However, the health officers of many States did not believe that plague no longer existed in San Francisco. The Treasury Department of this great country sent out a commission, composed of very eminent men, to San Francisco to investigate the existence or non-existence of the plague and to report thereon. It was an exceedingly unpopular thing in California for any one to admit that plague existed. No political party, and the government of the State was then in the hands of the Republican party, dared tell the truth. Some very important elections were about to be held in the State of California. What did this commission, sent out from Washington, do, when the entire country was most anxiously waiting for results of their investigation? I shall quote *verbatim et literatim* from a letter of the Surgeon General of the Marine Hospital Service (of March 26, 1901) replying to a request by the State of Louisiana through its proper health officer for a report of the commission:

"Referring to your letter of the 21st inst., requesting a copy of the report of the Commission sent to San Francisco for the purpose of investigating the existence or non-existence of plague in that city, I have to inform you that said report will be shown to any personal representative of yourself who may apply at this office, but cannot at the present time be sent out."

The report was *never* made public or made known to any State health officers concerned. Texas alone, through Governor Culbertson, demanded that report and obtained it. Had the report been made public, or had a Republican government admitted the existence of plague, the Republican party would have lost the State of California. In the meantime a vessel, the "Curacoa," with a clean bill of health from the Marine Hospital Service, went from San Francisco, Cal., to Mazatlan, Mexico, and infected that town with the most devastating epidemic of bubonic plague known to modern times.

Could there be a more dishonorable act on the part of the government than to withhold this important knowledge for political reasons? Acting upon the information which she forced, Texas put a quarantine upon Chinatown in San Francisco, and thereby perhaps prevented the spread of plague into her territory.

It has been made the duty of the Public Health and Marine Hospital Service to station an officer at all ports all over the world and to report infectious or contagious disease which may exist in that locality, to issue clean bills of health when none exist and foul bills when such disease exist. Numerous failures in this connection are on record. While this paper is being written we learn through the public press of two cases of yellow fever in Havana, not cases that have been brought there from Mexico, but originated in Havana itself, yet the Marine Hospital Service, with its officers stationed in Havana, have failed to report the existence of yellow fever, and this, too, after that service has been urged by the Louisiana State Board of Health, by Texas, and by Alabama, to make careful investigations of the conditions in Havana, as for some time rumors have been afloat of the existence of yellow fever in Cuba. It was not denied that dengue was epidemic in Havana just as it was in Ocean Springs in 1897, but in response to repeated telegrams from the health authorities of Louisiana and Alabama the head of the Marine Hospital Service made excuses not to send a special officer to Havana to investigate. Those telegrams are on record, and if it now transpires that Havana was infected with yellow fever all along we simply have another example of the sort of faith the Federal health authorities may be expected to keep with the South.

I propose to touch very lightly upon the point of the great danger to the South of placing in the hands of the government centralized in Washington the sole power of quarantine. There is no power in human government more absolute and more crushing than quarantine. That danger was so easily pointed out through a memorial presented to Congress by the Louisiana State Board of Health, through its president, Dr. S. R. Olliphant, in 1893. A reprint of this memorial has appeared in and has been discussed so recently by the public press that it would be useless for me to dwell on it further than to reiterate a statement therein made that the powerful aggregation of Eastern capitalists could at any time bring to bear on a central bureau in Washington such pressure that any of the Gulf ports might be temporarily closed or placed at such disadvantage that commerce would be forced to seek the more favored ports of the North Atlantic. If any one doubts this I would mention that a practical illustration of this was given a few months ago. The Surgeon-General of the Marine Hospital Service, without consulting any one or condescending to give his reasons, issued an order which stopped all shipment of fruit through the port of New Orleans. It was never claimed by any one who knew anything of such matters that such shipment could be any danger to the points to which the cargo would have been carried. Representations to this effect were made to the Marine Hospital officer in command here and were tacitly acquisced in, but unfortunately the ethics of the service prevented any official expression from that officer concerning the acts or motives of his superior officer in Washington. The Surgeon-General made absolutely no effort to avoid this hardship to the port of New Orleans.

I should say that at the time of the memorial above spoken of there was a bill before Congress which contained provisions very similar to what is now being advocated in the way of "National Control." That bill was defeated by the efforts of Louisiana, Alabama, South Carolina, Florida, Texas and New York. In its stead "an act granting additional quarantine powers and imposing additional duties upon Marine Hospital Service" was passed. The act with above title was approved February 15th, 1893. The Surgeon-General immediately had it published in pamphlet form and distributed it widely.

I was surprised to learn at the meeting at which Dr. Lowe read his paper that there were so many present who did not know anything of the existence of the bill or any of its provisions. The chief point of this Act of Congress is that it is made the duty of the Marine Hospital Service whenever any State service is inadequate to institute and enforce additional quarantine measures. In this connection it is proper to mention that during the last three years at the conference of the health authorities of the State of Louisiana, Alabama and Texas, which were called for the purpose of framing uniform marine quarantine regulations for those States, a prominent representative of the Marine Hospital Service was present and approved the regulations adopted. The Surgeon-General subsequently approved of them.

There is one point which I had almost forgotten to refer to. There seems to be a belief upon the part of many that if the Marine Hospital Service or the United States Government had charge of quarantine all it would have to do in case of yellow fever occurring, say, in Louisiana, would be to tell the neighboring States just how and to what extent there would be quarantine. Had I not been told that such a delusion was being entertained by many commercial men and even some doctors, I wouldn't believe it. I want to say that even if every State in the Union completely surrendered its power of quarantine (and of course this will never occur), the United States Government could push a man from infected Louisiana just across the border of Texas, or Mississippi. or Alabama, but he would not get any further, and the Lord help him when he got there.

As to the work done here in this city during the summer, I would say that I would not take away one bit of the credit which goes to the Marine Hospital Service. They have worked very hard, but no one, at least no medical man, would claim that the work was scientific. No scientific knowledge of yellow fever was required. Cases were reported to them and they fumigated the houses more or less effectually. I only regret that at times their work was exceedingly brutal.

In conclusion, let us for a moment consider the illogical aspect of the present wish of certain people to have the United States Marine Hospital Service assume control of all maritime quarantine operations at this port.

On the one hand, we have the record of original and successful work by the Louisiana State Board of Health extending back some twenty years with only two outbreaks of fever, viz.: that of 1897, when the disease was allowed to come in by the want of vigilance on the part of the Federal authorities to whom the protection of the Mississippi Gulf coast was entrusted, and the one of 1905, when, for the first time since 1893, the State of Louisiana did not send her own medical officers to the Honduras ports, being over-persuaded to rely upon the reports of the Marine Hospital representatives at those ports, from which those representatives continue to issue clean bills of health until yellow fever was epidemic in Belize and fully developed at Port Cortez.

Could anything be more illogical than to do away with the State service which has given protection all these years and to rush blindly to the decision, irrevocable if once taken, to put all future reliance on those whose failure to justify the trust put in them in 1897 and 1905 has been the apparent cause of the only invasions of yellow fever we ahve suffered?

In arguments brought forward against the continuation of the State control of maritime quarantine a prominent journal has quoted the proverb that "No chain is stronger than its weakest link." If we are to depend upon the United States Marine Hospital for timely warning of the existence of fever we need go no further back than events at Mississippi City and Gulfport during this past summer to show how weak was the link on which public dependence was placed in the service officer stationed there. That officer remained unconscious of two nests of fever, aptly referred to by the press as being under his very nose, until the State Health Officer of Alabama arrived on the scene and discovered them.

If there is any lesson to be learned from the experience of recent years it is clear to the writer of this paper that, instead of voluntarily surrendering any portion of her right to control maritime quarantine in her own waters, it behooves the State of Louisiana to strengthen the lines of defense by keeping her own trusted officers on watch at every point of danger, placing no further reliance on strangers not responsible to her authority.

Let others who choose to do so abandon all semblance of acting on the divine right of self-defense, bowing their necks in humble abasement before the one-man power bureau enthroned in Washington, but with her prestige, her trained force of officers and unsurpassed equipment, there is surely no excuse for Louisiana to retire from the control of maritime quarantine in which she has taught the civilized world all it knows on the subject.

MEETING OF NOVEMBER 25, 1905.

DR. C. C. BASS read a paper on:

"Report of a Case of Uncinariasis."

P. W., aged 22, male, white, single, Folsom, La., laborer, admitted November 14th, 1905.

Complaint: Weakness and vertigo, five years.

Diagnosis: Uncinariasis.

Family history: Father living, well. Mother dead, 28, typhoid pneumonia. Brothers and sisters living, 7; all well. Brothers and sisters dead, 2; one killed, one typhoid pneumonia. One uncle died of tuberculosis. Others negative.

Personal history: Never sick until had typhoid pneumonia, five years ago, lasting ten days. No rusty sputum, but other cases at the time in the family did have. Has never been confined to bed since, but has been very weak and gives the history of the following symptoms: Dyspnea on exertion, dizziness, headache, weakness and ravenous appetite. For past twelve months had voided an abnormally large amount of urine. Is sure he has not had ground itch since a year before he got sick, up to which time he was very robust and healthy. Had had it a few times prior to this.

Status Presens—Patient is about 5 feet 10 inches, 140 pounds, fairly well muscled; skin, conjunctivæ and mucous membrane very pale and anemic. Little hair on face and pubes, boyish voice and ways. Pupils react to light and accommodation, right larger than left. Teeth good, veins of neck large and pulsating. Heart: Point of maximum impulse in fifth interspace, 1½ or 2 inches to the left of mammary line. Marked pulsation all over pericardium. Relative cardiac dullness extends two inches to the left of mammary line and 1 inch to right of mid-sternal line. Murmur at apex, first sound not transmitted to left; murmur in second left interspace, first sound which can be heard nearly all over pericardium. Lungs negative. Liver dullness four inches in mammary line. Spleen just felt beneath costal margin. Urine Sp. Gr. 1010; no albumen. Blood hemoglobin 25%, reds 2,457,500, whites 5,035, eosinophiles 16%, normablasts, poykilocitosis and anisocitosis. Feces showed enormous numbers ova uncinariæ. An eight grain specimen of the one normal stool to-day, diluted with water to 120 drops, and the uncinaria eggs counted in one drop, showed 1,576. Each drop represented 1-15 grain, so one grain would contain 23,640. I don't know the weight of this entire stool. Simon gives average weight of daily feces 165 grammes; Schmidt and Strasburg 131 grammes. Taking, say, 150 grammes, or 2,325 grains as an average dail amount, and multiplying the number in one grain by it, we have the figure 54,953,000.

Treatment—Patient put on iron, quinin and strychnin and on November 17, given liquid diet only and magnesium sulphate 1 ounce, morning and evening. Nothing but water after the last dose. Next day was given thymol, grs. 15, six, seven, eight and nine a. m., Rochelle salts one ounce at ten. Two thousand and seventy hook worms were recovered from this treatment. The evacuations contained pea hulls or skins, which he had not eaten for three days. This shows how difficult it is to clear out the alimentary canal. Patient felt no effect from the thymol and blood pressure actually increased from 120 on the 17th to 125 on the 18th at 1 p. m. Patient "complained" of feeling stronger and better than for several months in two days.

Blood examination on November 23, five days after treatment, showed hemoglobin 40%, reds, 2,987,500, whites 3,050, eosinophiles 12%; blood pressure 130; pupils equal. Was given two c. c. pills November 22. November 23, liquid diet and magnesium sulphate, one ounce, morning and evening and nothing but water after last dose. November 24 was given 20 grains thymol at 6, 7, 8 and 9 a. m., each dose being preceded one-half hour by 20 grains sodium bicarb., with the idea of dissolving the mucus which covers the worm and expose them better to the action of the thymol. Two ounces of magnesium sulphate were given, one at 8 and one at 10. Result in ten hours, one-half gallon liquid feces, containing seventy Uncinariæ Americana, some lumps of thymol. One drop of this feces contained sixty uncinaria eggs. This multiplied by the number of drops in ½ gallon, would give 1,843,200. Regardless of the 80 grains of thymol that day, patient was able to get up and take the train unassisted for home on receipt of news of a death in the family.

Special points in the case are: Enormous number of eggs, showing what a prolific source of infection one case would be if all eggs were hatched and taken into the body. From this patient, 54,000 a day could get 1,000 worms, or a rather severe infection, or the entire population of the City of New Orleans could be infected in six days. It also emphasizes the point that patients may not show much evidence of infection until their vitality or resistance is lowered by some other disease, as, in this case, pneumonia. Though patient had not had ground itch, the only source of infection, for a year, he showed no evidence of the disease until he had pneumonia.

Dr. J. M. Batchelor read a paper on:

"A Report of Three Cases of Intussusception."

Intussusception is referred to by writers on the subject as being of rare occurrence. Out of 100,000 cases diagnosed in the Charity Hospital in the last ten years there were but 11 of intussusception. It has been my opportunity to see four cases in the last three years and the apparent rarity of the condition would suggest the probability that many cases escape diagnosis, and that oftentimes cases that had passed undiagnosed would be recognized if the possibility of this condition were borne in mind. It will be well to recall certain facts that are of special significance with respect to diagnosis of this condition. It should be remembered that intussusception occurs most frequently in the early years of life, 29½ occurring in the first year of life and 53% of acute cases occurring before the eleventh year. The location of the intussusception is usually at the ileo-cecal opening and in children three-fourths of the cases are ileo-cecal. The mobility of the cecum and the entire colon in early life predisposes to this variety of intussusception. That symptom found in the greatest number of patients, and therefore to be regarded as most suggestive of intussusception when found in conjunction with other symptoms, is the passage of blood and mucus from the bowel. Of secondary importance to this is occasional vomiting. Tenesmus and a desire to go to stool are the least frequent symptoms of this condition. Therefore in intra-abdominal conditions requiring some exclusion in diagnosis if these facts be borne in mind—to-wit, that intussusception occurs in a great majority of instances in early life; that it is most common in the first year of life; that the invaginated bowel and resulting tumor should be felt in the great majority of instances along the colonic circle, and that vomiting is not constant, but that the passage of blood is a symptom appearing in practically every case—a diagnosis of intussusception should be easily arrived at. The following cases are reported, one of which was diagnosed, two of which were not diagnosed, as illustrative of the possibility of failure to recognize those sub-acute and chronic cases that develop insiduously in which symptoms occur with such infrequency as to permit the surgeon to overlook their importance and fail to make a correct diagnosis.

CASE 1.—Age 9 months, suddenly seized with acute pain in the abdomen evidenced by crying and flexion of the thighs, constipation, unable to secure proper bowel movement, occasional passage of blood and mucus with no fecal matter. The abdominal parietes were rigid and tenderness marked over the entire abdominal area. Intussusception suspected from the symptoms and age of the child. Under general anesthesia a large oval-shaped mass just above and to the left of the umbilicus was readily detected. This condition had existed for twenty-four hours when she fell under my observation. An immediate operation was done and the following extraordinary and rare condition was found: Invagination of four inches of the ileum, caput-coli, appendix and a portion of the ascending colon into the transverse colon. This intussusceptum and intussusception was in turn invaginated into the descendig colon. Reduction was accomplished with the greatest difficulty; the invaginated bowel appeared very much discolored and small spots of necrosis were apparent. The condition of the child made it necessary to close the abdomen at once hoping that the discolored area would clear up. The shock of the operation added to the pre-existing shock from the intussusception resulted in a fatal termination within two hours after the operation.

Case 2.—Chronic intussusception. No diagnosis until after death. Age 54; on admission to the hospital patient complained of cramps in the abdomen. Cramps were intermittent and daily. He vomited occasionally, but was able to eat and be up and around, though seldom free from pain in the abdomen. He noticed at times a lump in his belly. Complained of constipation. Palpation of the abdomen revealed a large apparently fluctuating mass just above the umbilicus, which was thought to be a pancreatic cyst. The patient was prepared for operation, but took the anesthetic so badly that the operation proceeded no further than the attempt to anesthetize. The patient died on October 9, and on autopsy a large mass of invaginated bowel of the ileo-cecal variety was found, a portion of the invaginated ileum being gangrenous. This condition had persisted sixty days.

Case 3.—Age 10 years; four weeks before admission, after hearty meal, was seized with cramps in the abdomen referred specially to the hypochondrium. Cramps were intermittent, appearing several times a day and of great severity. During his first two days of illness the patient remained up. There was no vomiting in these first days. Bowels were active with occasional traces of blood in the stools. The symptoms varied little during the first four weeks of his illness, at the end of which time he passed into my hands. My examination was almost negative. The rigidity of the abdominal muscles made it impossible to satisfactorily palpate the abdominal contents, the only information drawn from attempts at palpation being the presence of intra-abdominal tenderness. The child noticed occasionally a swelling in the right hypochondrium, the cramps and the swelling appearing and disappearing synchronously. He occasionally passed blood in the stools, on one occasion pure blood. I concluded the case to be one of partial intestinal obstruction, the cause of which I was unable to determine. Under general anesthesia, and on the operating table just at the moment of operation, I was enabled to define a tumor in the right hypochondrium as large as an orange. The abdomen being opened an ileo-cecal intussusception was found. This was easily reduced, the abdomen closed and the patient made a rapid recovery. In this case the appendix was amputated, the long interference with its circulation while in the intussusception having left it pale, edematous and prone to inflammation. These cases are of diagnostic importance.

The surgeon should be able to specifically recognize this condition, and the prognosis of the case is absolutely controlled by the duration of intussusception. Early diagnosis, early operation, low mortality. The statistical mortality from operations is now 53%. Nothing in the condition predisposes to such a mortality, but rather is it due to failure to make early diagnosis.

Dr. Homer Dupuy read a paper on:

"Primary Nasal Diphtheria, with Report of Cases."

While we seldom fail to recognize a nasal extension of pharyngeal and tonsilar diphtheria, a primary implantation of this disease in the nasal cavities is apt to pass unobserved. Unless we are wise enough to appreciate the fact that the mild diphtheritic rhinitis may simulate head cold, we are liable to commit what might prove a grievous error. In this very slight local and systemic reaction lurks the gravest dangers if not to the patient, at least to those in the immediate environment and to the community at large.

While it cannot be reckoned a common disease, its occurrence is more frequent than is generally supposed, and as many cases run their course unrecognized, this explains the statistical evidence which would seem to greatly lessen its frequency. But in the last four or five years there is a marked increase in the number of such cases, both in literature and in hospital reports. Undoubtedly the results of a more careful investigation of all cases showing the slightest trace of a membrane in the nose partly explains its apparent increase.

Bacteriologic evidence permits a clear-cut division of fibrinous rhinitis into the diphtheritic and the non-diphtheritic. In the non-diphtheritic the pathogenic role is assumed by any of the pus-forming micro-organisms. Relating to this division of membranous rhinitis, the records of the Eye, Ear, Nose and Throat Hospital, in the service of Drs. DeRoaldes and King, are interesting. Dr. Kooken, a resident surgeon of the hospital, has kindly prepared a tabulated report, which shows that, from 1896 to 1904, 81 cases of fibrinous rhinitis are recorded. Thirty-four were non-diphtheritic and 47 diphtheritic. This differentiation is based on the microscopic examinations.

The microscope is, after all, the crucial test, for it cannot be emphasized too strongly that the clinical behavior of these two forms of membranous rhinitis is so similar, particularly the mild diphtheritic variety, that a naked-eye diagnosis is absolutely untrustworthy.

The usual clinical picture shows nasal cavities obstructed with grayish white exudates, adherent to the mucosa of the septum and turbinal bones. They are of a fibrinous consistency and leave a bleeding surface when forcibly removed, there is a marked tendency to a reformation of the membranes, while epistaxis is a common symptom. There is little disposition for the membrane to extend to the neighboring parts. There is very slight, if any, systematic reaction and no paralytic sequelæ. The child breathes heavily and mostly through the mouth. In the infant the breathing is markedly snuffling in character, and there exists a serious inability to take the breast. The affection abates in a couple of weeks, although judicious treatment along more modern lines ought to reduce this period. In these mild forms it appears to be a purely local disease. We must recognize that after the initial infection by the diphtheria bacilli other micro-organisms enter the diseased area, setting up particular changes, which tend to vary the pathological picture, and, it might be, awaken a latent affection into one of pronounced virulence.

In general features, diphtheritic and non-diphtheritic rhinitis follow the same clinical course.

We occasionally meet with a still more benign type, in which only a trace of membrane is visible, while the nasal secretion is abundant and so acrid that excoriations are visible along the anterior nares and the upper lip. Occasionally, there is light epistaxis. The microscope has given a positive diagnosis in just such cases. Unless we are on the alert, the nature of the affection might escape us.

We have also to reckon with a graver form, in which we find a severe systemic intoxication manifesting itself in albuminuria, general depression and a very rapid heart. Marked cervical adenitis has been noted in these severe forms. Why some cases are benign and others severe is probably due either to the variations in virulence of the bacillus or to individual susceptibility.

That a fatal issue is possible is exemplified in a case coming under my care during this present month at the Eye, Ear, Nose and Throat Hospital.

A colored infant, aged three months, was brought to this clinic for the relief of nasal obstruction. The breathing was difficult and entirely by the month. Nourished badly. Both nostrils completely obstructed. Throat normal and no laryngeal involvement. Removal of membrane with forceps improved breathing and permitted nourishment. Culture, taken to Board of Health, gave positive results. Child died 48 hours after being first seen. Close inquiry proves positively that the child died from the toxemia.

The younger the patient the greater the prognosis. Interference with the child's capacity to take the breast may be partly responsible for the higher mortality in infant life. My tabulated cases show that 36 out of 47 cases of nasal diphtheria occurred under ten years. It has been advanced that the affection is more malign when the membrane occurs nearer the posterior nares. This is plausible, for the richer blood supply of that region undoubtedly favors a more rapid absorption of toxins.

Some observers, while admitting nasal diphtheria to occur independently, also maintain that in a large number of instances the extension occurs in the adenoid deposits in the naso-pharynx, which is primarily affected. There is no denying this possibility that it must be kept in mind, if we wish to trace the initial point of infection in these nasal diseases.

Dipththeritic rhinitis evinces a persistency which puts our patient and therapeutic resources to the test. Three weeks is the usual course before the microscope demonstrates a complete disappearance of the disease. This persistency may partly arise from involvement of the accessory sinuses, which from their anatomical relation to the nose can hardly escape the infection. A favorable nidus is thus secured to the diphtheria bacilli, which in turn re-infect the nasal activities at a period when the disease seems to have spent its force.

The contagiousness of this form of diphtheria is scarcely less than in the throat manifestations. Bearing on this question, I will cite four cases of nasal diphtheria occurring in my private practice this fall, in the same family and at the same period of time.

Dr. Maxime Landry, the family physician, can verify the authenticity of the incident.

The first case developed in a boy aged four, who showed a membrane in the left nasal cavity a few days prior to the appearance of a membrane in the nose of three other children, aged respectively 18 months, 6 years and 10 years. These formations developed simultaneously. Careful examination showed normal throat in all, except, in the 18 months child, I was able to institute rhinoscopic examination of the post-nasal space, in which I could not recognize any membranous deposit. The membrane was limited to one nasal chamber in two cases. There was no systemic disturbance. The youngest child experienced great difficulty in breathing at night, the natural result of nasal obstruction in one so young. Separate cultures were sent to the pathologist of the Board of Health, with a request to make separate examinations. The report gave positive results in each case. After three weeks, the patients seemed clinically free from disease and this was supported by the control cultures. In the way of treatment, I found Dr. Landry carrying out effective nasal irrigations. I came prepared to give antitoxin, but after consultation with my confrere agreed to dispense with it. I confess now that I erred in not insisting on the serum, for reasons to be discussed shortly. Recognizing our inability to differentiate clinically between the mild forms of diphtheritic rhinitis and the purely fibrinous variety, we must, therefore, isolate every case showing an exudate in the nose until a bacteriologic examination is instituted. Several may be necessary before we can safely reach a definite conclusion, and a control culture only can assure us that the disease has ended.

The head cold in the child covers a multitude of errors in diagnosis and not infrequently it is only when a tonsilar or pharyngeal diphtheria appears in some member of a family that closer scrutiny picks out the victim of the head cold as having been the hitherto innocent and unrecognized carrier of a much-dreaded disease.

Improved methods of investigation and diagnosis now permit us to include many cases of what in pre-microscopic days was simply termed "fibrinous rhinitis" into the class of positive diphtheritic affections.

Even the unilateral manifestations, usually regarded as quite characteristic of non-diphtheritic rhinitis, I have seen contradicted in two of my cases, in which the membrane was distinctly limited during the whole time of the disease to one nasal chamber. Cultures in these instances showed the diphtheria bacilli.

The question of local treatment can be summed up in two words, nasal cleansing.

By its thorough performance, much of the fibrinous exudates and the accumulated muco-purulent secretions are washed away, thus reducing the period of membrane formation, the amount of toxin absorption, and the danger of aspiration of the pathogenic bacteria into the larynx. To attain this result the smallest detail assumes greatest importance. Injections of the nose, to be effectual, can only be carried out by willing and intelligent help. The physician himself, at each visit, must apply every detail of the local treatment, which will have the two-fold effect of benefiting his patient and of instructing the one who has assumed the duties of nurse. Vigorous spraying of the diseased part with an apparatus of superior quality is adequate and most efficient. The child, if there be no contraindication, such as a weak heart, is held upright on the lap of an assistant, a sheet wrapped tightly and pinned around the chest will secure the arms, the lower limbs are held fast between the legs of the assistant, while one hand on the forehead of the child will steady the head. Only by such manipulations can we subdue our patient and treat him intelligently.

Should the patient be too ill to carry out this very essential procedure, then a glass syringe, with soft rubber tip, can be used, while the child is placed on its side. We must remember to comply with the anatomical formation of the nose and syringe it with the instrument held horizontally and not vertically. The possibility of fluid reaching the middle ear by these irrigations has been grossly exaggerated and does not justify the giving up of so efficient a measure.

Peroxide of hydrogen is a two-edged sword and is much abused. In too strong solutions it causes erosions of the epilethial tissues and thus invites further infections. In weaker solutions it can be used sparingly and with benefit. The more frequent irrigations can be practiced with alkaline solutions, containing either glycothymolin, or ingredients which are best represented in the well-known Seiler's alkaline tablets.

The direct application of drugs assists materially. Although recommended, I mention carbolic acid and formalin only to condemn them as being too irritant. Icthyol, gr. xxx-xl, petroleum ointment 1 oz., made into a salve and applied liberally by means of a cotton tipped applicator, as far in the nasal cavity as possible, where it will dissolve and reach the deeper areas, is worthy of recommendation.

And last, but not least, among the local astringents, is argyrol in solutions of 30 to 40%, which can be safely used every hour by injecting it into the nasal chambers through a pipette.

While the irrigation and topical treatment are essential, much can be accomplished by the instrumental removal of the membranous deposits. This I consider the duty of the attending physician. A skillful use of forceps and cotton tipped applicators will give clean surfaces over which the antiseptics above mentioned can be immediately applied.

But to all this is offered the criticisms that such details in treatment require more labor, patience, time and perhaps skill than most of us are willing to bestow on these cases. The excuse, however, is not acceptable in the face of a disease, the outcome of which might involve a fatality. And now we must clinch the question of serum treatment, for I believe this disease, which in spite of our best efforts runs along for at least three weeks, in some recorded cases two months, can be shortened by the administration of the antitoxin. I have, only recently, begun to realize my own inconsistency and that of the profession, as a whole, on this important question. We judiciously apply it on the mere suspicion of diphtheria in the throat, and yet we hesitate to inject the serum in the nasal form, fortifying ourselves with the afct that in this region the disease is apparently innocuous. But even this is not absolutely true, as accumulated evidence in literature proves that some of these cases have died, either from toxemia or from an extension of the disease into the larynx. Of equal weight is the knowledge that these apparently mild cases of diphtheritic rhinitis are sources of potential danger to their immediate surroundings, to communities, and to institutions where a large number of children are congregated.

Above I have already insisted on isolation in all cases of the disease. But as virulent diphtheria bacilli may persist in the nasal mucosa for a long period after the case is clinically well, a lurking danger may still exist even when the subjects are discharged and are allowed the free intercourse which naturally follows.

It is worthy of note that the nasal diphtheria cases, which numerous reports show to have caused similar, yet graver infections in the throat, had not been given the antitoxin. In fact it is almost a universal, but none the less blamable, practice not to give the serum in this variety of the disease. How illogical, when we remember that it is clinically demonstrable that the antitoxin has a resolvent action on the diphtheritic membrane wherever situated. Its gradual yet certain disappearance means less infected secretions and epithelial debris, and diminished toxin absorption, with a consequent reduction in the possible spreading of the disease. This is equally applicable to nasal diphtheria—if anything, more so as this form is infinitely more resistent.

Our conduct in the management of a case of fibrous rhinitis should be as follows: to first consider it as possibly diphtheritic. A culture should be taken immediately. Pending the microscopic examination absolute isolation is to be insisted on. Should the result prove negative and yet the affection from a unilateral develop into bilateral invasion another culture should be prepared for further information. If the evidence be plainly non-diphtheritic the case can be managed with a local treatment—if otherwise, the logic of modern serum therapy points unmistakably to the administration of the antitoxin. Two thousand units as the initial dose should suffice for the more benign type, while the severe forms will require larger doses.

In conclusion, I have written this paper for the specific purpose of calling attention to a form of diphtheria deserving our serious consideration, and to advocate the use of antitoxin in its treat-

Communication.

The Careless Handling of Typhoid Stools in Country Parishes.

HOUMA, LA., DECEMBER 6, 1905.

I beg leave to take exceptions to Dr. LeBlanc's article in last issue, when he says that "typhoid fever is rare in the country, and that the stools being thrown away and there being no general water supply into which the stools are washed, no more cases are liable to occur."

The drinking water of our country people is, for the most part, cistern unfiltered water. Now the stools being thrown away in the backyard and dried in the sun into subtle dust that is blown on the roof of every surrounding home, are ready, when a rain comes, to be washed as quantities of bacilli typhosus into cisterns, which in time, become a new source of infection. My experience, which dates back a quarter of a century, proves that typhoid is spreading rapidly in our rural districts by these means, and it is not so rare as the kind doctor believes. The so-called continued fevers are mostly all of typhoid origin, and if the doctor will make a microscopical study of these cases he will soon bear me out in this.

We have numerous types of typhoid infections, and the symptoms vary with these types, but all will give the bacteriological conclusive test. The Widal agglutination is not conclusive, and may lead to error.

It is time that our country physicians realized that we have typhoid fever in our midst, that it is spreading every year more and more, and that precautionary measures should be preached to the laity about the necessity of disinfecting or burning the stools of such patients as present continued types of fever. I know that whenever such precautions were taken, together with the boiling of the cistern drinking water, I have succeeded in restraining the spreading of such fevers. Diagnose it what you will, but if you take the precautions alluded to above, you will have achieved such results as to conceive you that typhoid fever is responsible for two-thirds or more of our continued *types of fevers.*

DR. CHAS. M. MENVILLE.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Health Matters.

As this is being written it is not known in whose hands will be placed the direction of health matters in Louisiana during the new year and the next dangerous season. The Governor having declined at this crucial time to be guided by nominations of the State Medical Society in his appointment of members of the State Board of Health, as has been suggested, it is not likely that his selections will meet the general approval of the medical profession of the State. There is too much probability that politics and personal favoritism will play a prominent part in the program.

It seems to us that the Governor will have lost a fine opportunity of placing the responsibility chiefly where it belongs—namely, on the medical organization of the State, representing all sections, both rural and urban. In health matters the medical profession should be the best judge as to the fitness of its members. The State has finally to depend upon its medical men for the preservation of its health; hence, it should let them determine which ones among them are most fit at any particular time to do its sanitary work in the best manner. We note that amid the criticism, the condemnation and even the abuse which have been directed against the management of health affairs in the city and State, no part has been aimed at the authorities who appointed the health officials. The doctors alone bear the brunt. Let a quarantinable disease make its appearance and if the physicians honestly tell the truth about it they are anathematized by all those whose pockets get hurt; on the other hand, if they are weak enough to evade their duty, even with the connivance of those who occupy the seats of the mighty, and the truth does come out, they are damned anyway. They deserve to be in the latter instance, but as they are going to catch it no matter what happens, and the entire profession justly or unjustly gets a share of the discredit, it would seem only fair that, through its organization, it should have the opportunity of saying who shall be its representatives in authority, its officers in command.

A special meeting of the State Medical Society has been called for next month in order that all matters pertaining to health in this State shall be given most earnest attention sufficiently long ahead of the meeting of the Legislature. We urge that due thought be given to this question of the manner in which our health officials shall be chosen. Incidentally we advise that set papers and oratorical efforts be discouraged and simple and business-like discussions on none but strictly pertinent subjects be arranged for, one of the most important of which must be relative to the annihilation of mosquitoes, particularly the stegomyia and the anopheles.

In the meantime the constituted health authorities, whoever they may be, whether their appointment or their retention in office has our approval or not, must have the earnest co-operation of the profession in all their efforts to preserve the public health. The JOURNAL assures them in advance of loyal support as long as it can consistently give it.

The New Year.

The consistent progress of medicine during the past year compels a sense of congratulation among those who have shared in the privilege of this advance. In every field a more exact application of knowledge is the vogue.

The sufferings of the human race have been reduced by better methods of anesthesia; surgical technic has improved and the intelligent use of medical methods has gradually evoluted. A violent reaction, even to the point of revolution, has gained ground against patent and irregular proprietary medicines and the serums of innumerable variety have resolved into two or three of accepted merits.

Rost has cured leprosy with a simple derivative from the bacilli of that disease, called "leprolin," and it promises well. Behring claims to have solved the tubercle menace and the world is almost satisfied that the organism of syphilis is identified in the "*Spirocheta pallida*" of Schaudinn and Hoffman.

Perhaps no more startling anouncement has been made than this last named; for fully 27 specific organisms have so far been named for the disease. Both syphilis and leprosy have been inoculated into apes with reproduction of these two diseases, but the experiments with the syphilis organism have as yet been limited.

The morbid craze for light therapy has gradually resulted in an average of intelligent application and it is no longer put forward as a "panacea," while it each day gains further usefulness in its exact application.

Sanitary education of the masses has gradully occasioned a broader mode of public hygiene and another year may find disease out of reach.

The New Orleans profession, the P. H. and Marine Hospital Service, and above all the people of New Orleans deserve much credit for their struggles with the fever plague and its mosquito breeders. The New Year must find a fresh spirit of endeavor and free of the burdens of that gone by. With united efforts no such experience need be anticipated nor suffered again, and New Orleans should fulfill its promise, forecast in the horoscope of a near future: Multiplied in population, blest in resources, encircled with prosperity, and pregnant with the impulse of a great achievement to be born as each page of an earnest people is spread before a public eager for the signal of its delivery.

Mississippi Takes A Stand For Pure Drugs.

The Leflore County Medical Society has passed the following resolutions:

> "Resolved That it is the sense of the Leflore County Medical Society that the Legislature of the State of Mississppi should pass a law requiring every proprietary or patent medicine, or food for the sick, offered for sale in the State of Mississippi to have its formula printed in plain Englsh on the label, and where any drug usually considered poisonous enters into the formula, that the word *Poison* in prominent letters also be inscribed thereon.
>
> "It is further resolved, That each member of this Society should make it his business to urge our representative in the legislature to do all in his power to have such a law passed."

We congratulate our neighbors on their progressiveness and we feel that the exploitation of such an effort must carry some weight in education if not in immediate results.

Collier's Weekly has for some time militated against patent medicines of the harmful sort and the *Ladies' Home Journal* has for years potently waged war against all sorts of patent medicines. Every legislature owes its public some protective action against these menaces to health and it is only a matter of time when a serious people will demand this.

The average public newspaper or periodical owes too much of its income to the advertisements of pretentious remedies to grow heroic regarding them—but when legislative enactments forbid the sale or public notice of these, then we may hope for relief.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of Dr. F. W. Parham, Assisted by Dr. F. Larue, New Orleans.

Lipoma of the Submucosa of the Stomach.—Dr. Hartman (*Progrés Medical*) addressed the Société de Chirurgie (October 11, 1905), concerning a case of Dr. Benaky (Smyrna), presenting a plaster cast of the specimen.

At the autopsy the stomach was found to be bilobular; on opening it there was found near the pylorus a tumor, flattened, consisting of three lobes and umbilicated in the center. It measured 2½ inches in length and 1½ inches in width.

It proved to be a fibroma developed in the submucous cellular tissue.

Wound of the Heart—Suture—Recovery.—Mr. Picqué, (*Progrés Medical* Oct. 28, 1905), speaking for his interne, relates to the Société de Chirurgie the case of a young man, aged 24 years, who was brought to Hospital Bichat last July, thirty minutes after being stabbed in the left breast.

The heart being thought injured, intervention was immediate.

A costal flap was made including the third, fourth and fifth ribs.

On raising the wounded tip of the lung the pericardium was seen filled with about 300 grammes (10 ozs.) of blood.

The wound of the left ventricle, obliquely upward and inward was bleeding; it was closed with two deep silk sutures, the pericardium with catgut.

The thoracic wound being closed without drainage, there ensued a hemothorax, which had to be evacuated on the second day.

The patient, discharged well three weeks previously, was shown to the Society.

Mr. Picqué communicates a second case, not exactly similar, in which the ventricular lesion was detected during a thoracotomy for a penetrating gunshot wound. As it was not bleeding, no sutures were applied.

DOUBLE PENETRATING GUNSHOT WOUNDS OF THE STOMACH—SUTURING—RECOVERY.—Mr. Reynier (*Progrés Medical,* Oct. 28, 1905) cites before the Société de Chirurgie for Mr. Savariand the following case: On the 20th of last September a woman was admitted into the hospital for two self-inflicted gunshot wounds of the epigastrium. Mr. Savariand operated three hours after, owing to abdominal distension and muscular rigidity. The patient at the time of injury was practically fasting.

Laparotomy revealed two wounds of the anterior surface of the stomach; these were stitched. On tearing through the gastro-colic omentum about one pint of blood flowed from the posterior cavity. No wound was found on the posterior surface of the organ. After recalling two cases, which recovered spontaneously, Mr. Reynier concludes that in cases of suicide when the stomach, nearly empty, is injured by a bullet of small caliber, it is wiser not to interfere.

A number of members present, including Potherat, Reclus, Delbet, Quenu, Routier, Legueu and others, dissented with Reynier.

Mr. Reclus particularly, in reply, stated that if he formerly advised abstention it was then due to the fact that surgical technique was far from being as perfect as it is now, and, for that reason, non-interference had given, at that time, better results.

Owing to existing knowledge he would not now hesitate to intervene in a case of penetrating wound of the abdomen.

It is the universal verdict, inasmuch as it is impossible during the first hours following the injury to make a precise diagnosis, and furthermore, as Mr. Routier very wisely remarked, if we wait until peritonitis develops, it would probably be too late to save our patients.

RESECTION OF THE UPPER SYMPATHETIC CERVICAL GANGLION FOR TRIFACIAL NEURALGIA.—Mr. Poirier had three patients. The first one remains cured after 30 months; his second case (operated six months ago, in May, 1905), is likewise well, with the exception of a slight crisis which lasted but one day.

In a third case, Mr. Poirier was unable, after a thorough search, to find any ganglion; he resected a small nerve filament which occupied its place. The patient, operated three months before, improved only temporarily.

Department of Obstetrics and Gynecology.

In Charge of DR. P. MICHINARD and DR. C. JEFF MILLER, of New Orleans.

ON THE EFFECT OF VENTRAL FIXATION OF THE UTERUS ON SUBSEQUENT PREGNANCY AND LABOR, BASED ON ANALYSES OF 395 CASES.—Andrews (*Jour. of Obst. and Gyn. of Brit. Emp.*, Aug., '05) bases his conclusions upon Noble's collection of cases in 1896, and upon all recorded cases he could find in English, French, German, American and Italian literature since that time.

1. Has fixation any influence upon subsequent pregnancy and labor? He answers thusly:

(a) *Abortion.*—As it is, we can only say that the evidence before us does not point to the fact that ventral fixation is very likely to cause abortion in subsequent pregnancy.

(b) *Disturbances During Pregnancy.*—Pain occurs in a considerable proportion of cases after ventral fixation.

(c) *High Position of the Cervix.*—Is recorded in many cases, and causes the most common difficulty met with after ventral fixation.

(d) *Lateral Asymmetry or Torsion of the Uterus.*—Noted in 5 cases. Cæsarean section performed in 3 cases; version in 2.

(e) *Malpresentations.*—There can be no doubt but that ventral fixation sometimes causes malpresentation.

(f) *Rupture of the Uterus.*—In 3 cases out of 189.

(g) *Cæsarean Section.*—In 16 out of 189. There can be no doubt but that the difficulty of labor was due to the fixation in 10 of these. The evidence is less strong in the other cases.

(h) *Postpartum Hemorrhage.*—So few cases have occurred, that, assuming that they would have been reported, we can conclude that postpartum hemorrhage is not a common sequel of fixation.

2. Are the difficulties in labor due simply to the fact that the uterus is fixed or are they associated with one particular method or technic?

He reviews the different methods of performing the operation, and then says the conclusion which is forced upon one from the foregoing table is that the method of performing ventral fixation which causes the least difficulty in future labor is that in which the uterus is fixed to the peritoneum alone, or to the peritoneum and sub-peritoneal connective tissue. The chief theoretical objection to this method is that fixation, or, as it is frequently called "suspension," will not be permanent. Fixation of the anterior wall appears from the table to be followed by less serious difficulties in labor than is fixation of the fundus.

The following conclusions are drawn from the 395 cases:

I. Ventral fixation may be the cause of great difficulties in labor.

II. These difficulties are due to a too rigid fixation of the uterus. Rigid fixation of the anterior wall is not followed by so much difficulty as fixation of the fundus or posterior wall.

III. The method of fixation involving least difficulty in labor is that in which the uterus is attached only to the particular peritoneum and sub-peritoneal connective tissue.

IV. In women who may become pregnant after the operation it is not advisable to anchor the fundus or posterior wall of the uterus by firm adhesions such as would be useful in cases of prolapse in older women; in other words, "suspension" should be performed in women who may subsequently become pregnant; fixation, in older women.

Department of General Medicine.

In Charge of Dr. E. M. Dupaquier, New Orleans.

Intratracheal and Intravenous Injections.—The reference to intratracheal injections, one of the ways of direct medication, toward which therapeutics has a strong leaning, as a "new way" (page 187, *Progressive Medicine,* March, '05), is a slip of the pen on the part of the able reviewer who quotes and abstracts Jacobs article on pulmonary infusions. Further in the same volume, page 257, Anderson's article on treatment of bronchial and pulmonary affections by intratracheal injections is also ably reviewed.

As a matter of fact, the direct introduction of remedial agents into the trachea has been noted as early as in 1894. Simply for citing only one record, in the practical *Formulary of Therapeutics and Pharmacology* by Dujardin-Beaumetz and Yvon (page 527, edition 1894), under the treatment of intermittent fevers, next to the hypodermic injections of quinin, the intratracheal injections of quinin are recommended; and the name of the assumed originator is given between brackets. (Jousset de Belleyme).

Regarding intravenous injections, also in a very able review (*International Med. Anual,* '05, page 87), Fortescue Brickdale remarks "that during the past 250 years, the various attempts," etc.

Why, 250 years form quite a period in history. So that neither the intratracheal nor the intravenous medications are new ways, resultant of late progress, as may be thought by many.

Immediate Percussion of the Chest with One Finger.—Recently practiced with gratifying success by Ernesto Ciaccianiga, is the final of irreducible simplicity, which would long ago have been universally adopted, but for the complicating factors of varying tenderness in the percussed and varying lightness of hand in the percussor. These are eliminated when percussion is performed not from the wrist, but from the proximal finger-joint. It is then strictly a "finger-percussion." I can confirm Ciaccianiga's favorable account of this method, which I have long employed, but only over the subcutaneous bony surfaces, and without excluding wrist movement. I have also learned that one finger is better than two. Inasmuch as precision in delimitation is proportionate to the lightness of the blow, this is of all methods that likely to provide most rapidly a helpless percussor, not only with fine results, but with the first essential in the technique, viz.: a stroke so gentle that the most delicate patient will not resent it. (William Ewart, M. D., F. R. C. P., *Progressive Med.* September, '05.)

Auto-Intoxication of Intestinal Origin.—Hemeter (*Dis. of Intestine,* '01) holds the view that in our efforts to combat intestinal auto-intoxication we may weaken by the administration of antiseptics the bactericidal powers which the normal intestine possesses. For this and other reasons, intestinal antisepsis is now, 1905, left without either rational or empirical basis. Intestinal anti-ferments rather than intestinal antiseptics are now used (W. Gilman Thompson, M. D.), etc. R. Schutz, in 1900, found that both castor oil and calomel, under certain conditions, injured the normal provisions for disinfection of the intestine.

Experience, after all, must be our teacher. It is very improbable that the belief in the the efficacy of calomel when carefully administered and in proper cases is likely to be shaken by the statements of opponents of intestinal disinfection, for improved peristalsis is one of the best means of ridding the system of toxic products. Calomel is too soluble a substance and it stays too short a period in the digestive canal to be an intestinal antiseptic in the ordinary sense of the word. (Appendix by Thomas Oliver, M. D., M. A., F. R. C. P. Translator of Lectures on Auto-Intoxication in Diseases, etc., by Prof. Bouchard, Paris. Second revised edition, 1906.)

Department of Therapeutics and Pharmacology.

In Charge of Dr. J. A. Storck and Dr. J. T. Halsey, New Orleans.

Facial Neuralgia Cured by Cocain Injections Into the Nerve Trunks.—Walter Spitzmuller (*Wiener Klinische Wochenschrift, No.* 40) reports a very severe case of trigeminal neuralgia, of several years' standing, upon which all the ordinary remedies had been used in vain, and a surgical operation was contemplated as a last resort. The patient was a woman, thirty-two years of age, who suffered almost constantly, and had repeated attacks of paroxysmal pain, lasting a week or longer. The following formula was used hypodermically:

℞	Cocain hydrochlorati	0.30 gramme
	Suprarenin	gtt. vi
	Aquæ destillatæ	20 c.c
Mt. Ft. Sol.		

Of this a half Pravaz syringeful was injected into the place of emergence of the left supraorbital nerve, and the same solution was then injected into the infraorbital, the mental and also the occipital. Immediately relief was afforded, the pain was as if "blown away." There was only left a temporary feeling of numbness in the distribution of the nerve. The patient now was able to take food, and had a good night's sleep, the first in two weeks. The next morning she had a little pain, and another half syringeful was injected as before, but in the right supra and intraorbitalis. During the next three weeks nine injections were given, after which the patient remained free from pain. Six months later there had been no return of the neuralgia. The case is most instructive and the expedient deserving of extended use. The injections are free from danger; but they have the single objection of causing local tumefaction and ecchymosis, which, however, passes off in a few days. The reporter calls especial attention to the importance of making the injections directly into the nerve trunks, or at least in their immediate vicinity, so as to bring the solution in contact with the nerves.—*N. Y. Med. Jour. and Phil. Med. Journal.*

Chronic Headache Treated by Massage.—Norstrom makes a running comment of the treatment instituted by him for chronic headache of inflammatory and muscular origin. The treatment consists of massage of the muscular insertions to the cranium, of the fleshy part of the trapezius, the sterno-cleido-mastoid, and other muscles of the neck, performed for a time sufficient to remove inflammatory deposits.—*Jour. American Med. Ass'n.*

Department of Nervous and Mental Diseases.

In Charge of Dr. P. E. Archinard and Dr. Roy M. Van Wart,
New Orleans.

Early Ocular Signs of Dementia Paralytica.—Holden (*Journal of Nervous and Mental Diseases,* November, 1905), after examination of seventy cases in the early stages of the disease, in the Manhattan State Hospital, uncomplicated with tabes(having exaggerated knee-jerks), reaches the following summary:

The shape of the pupils was perceptibly irregular in fifty-one patients, 70%, an abnormally high percentage considering the ages of the patients.

Irregularity of the pupils was found in thirty-two patients, or 45%.

The sensory pupil reflex was absent in sixty-one patients, or 87%; a very high percentage considering the ages of the patients.

The *direct light reaction* was perceptibly sluggish in one or usually both eyes in fifteen patients, or 21%.

The *direct light reaction* was entirely wanting in one or usually both eyes in twenty patients, or 28%.

The *convergence reaction* was sluggish in six patients, or 9%, in all of whom the light reaction was sluggish or wanting.

The size of the pupils ranged from 1.5 to 5mm., and in thirty-seven patients, or 55%, one or both pupils were smaller than average size for patients' age and refraction.

Great care was taken to exclude cases of alcoholic pseudo paresis.

Syphilitic Meningomyelitis and General Paralysis of the Insane.—Graham (*Jour. of Mental Science,* October, 1905) reports a case which is of great interest from the standpoint of diagnosis. The patient, an ex-policeman, *Aet.* 33, married, with no children, gave the following history: He had always been healthy. He used alcohol to excess, and twelve years previously had had syphilis for which he had been treated in a number of hospitals, chiefly for ulcers on the legs. A short time before coming under observation he had complained of weakness in his legs, staggering, trouble in talking and that nothing would stay on his stomach. Shortly after he was picked up unconscious. A month later he was admitted to the hospital where increased knee-jerks, slurring speech, and tremor of the hands and tongue were noted. Senation was normal and there was no nystagmus. A diagnosis of multiple sclerosis was made.

Two months later he was sent to an asylum, on account of degraded habits, tearing his clothes and illtreating other patients. His physical condition remained the same. An ankle clonus was noted on the right side. His mental condition varied. His memory was poor. He was at times elated. His pupils failed to respond to light. He became gradually more and more enfeebled. His speech became unintelligible, and he died of a terminal diarrhea three months after admission.

The autopsy showed great thickenings of the cerebral meninges, microscopical changes in cortex atrophy, increases of neuralgia, chromatolysis in the cells and plasma cells and lymphocyctes around the vessels. The spinal cord showed in addition to thickened meninges and a marginal degeneration, degeneration in the pyramidal tracts and in patches.

[The case is interesting as it shows how difficult it is in any given case to arrive from the clinical symptoms at a definite conclusion. The diagnosis of general paralysis from the symptoms and findings is open to doubt and it would be easy to explain everything present on the basis of a generalized syphilitic infection.]

A CASE OF TABES DORSALIS WITH INCREASED REFLEXES was shown before the Société de Neurologie de Paris by Dupré and Comus on January 7, 1904. The patient was a male of sixty-five years. He had had syphilis at twenty-five and typhoid at fifty years of age. He first complained of girdle sensation and fullness in the breast. Three weeks later he had pain and sensation of fullness and foreign body in the rectum. Later he had a sensation of narrowing of the nose which caused difficulty in his breathing. There was no bladder disturbance, no ataxia, no hypotonia and no Romberg's sign. The tendon reflexes were increased. The superficial reflexes were normal. There was disturbed sensation in the right arm over the thorax and lower extremities. The fundi were normal. The Argyll-Robertson pupil was present. Lumbar puncture showed a marked lymphocytosis.

At the meeting of the same society on February 4, Garnier and Thaon presented a case of *facial paralysis following erysipelas.* The patient, a male thirty-eight, had an attack of erysipelas in the right half of the face. Thirteen days later, after the complete healing of the erysipelas, a facial paralysis appeared. The patient recovered. In the discussion which followed Huet remarked that he had seen only one case of facial paralysis following erysipelas in 100 that had been under his care. Jeanselme and Huet at the same meeting presented the history of a case of leprosy with motor and sensory neuritis and hypertrophy of the affected nerves. The patient, a native of France, had lived many years in New Caledonia. In August, 1902, he noticed difficulty in moving the left hand, and atrophy of the hand and forearm muscles with a brownish discoloration of the skin. In February, 1903, he had pains in the various hypertrophied nerves. At the same time he had a facial paralysis and an erythematous eruption on his face. Scrapings from the face showed the presence of the leprosy bacillus. The erythema spread and involved the areas of distribution of the hypertrophied nerves. The patient improved under the internal administration of chaulmoogra oil and external application of ichthyol.

Department of Ear, Nose and Throat.

In Charge of **A. W. Roaldes, M. D., and Gordon King, M. D.**, New Orleans.

Fibroma of the Naso-Pharynx Treated by Injection of Monochloracetic Acid.—Harmon Smith, of New York, reports a case of a fibrous growth of the naso-pharynx, which on account of its firm structure and sessile character resisted several efforts at removal, and which he firmly subjected to deep injections of monochloracetic acid and caused its ultimate disappearance. He made use of a modified Coffin's post-nasal syringe, injecting three to five minims of the acid into the growth at intervals of from two weeks to two months until fourteen injections were made. Following each injection a portion of the tumor sloughed off until nothing remained of it and the boy enjoyed normal breathing and freedom from the ear complications that were beginning to arise.

The method has its disadvantages, however, in being rather too slow for a rapidly growing tumor, and in causing the patient severe pain if any of the acid is allowed to come in contact with the healthy parts of the throat. Smith is to be congratulated on the success of the treatment in this particular case, as such tumors are exceedingly difficult to eradicate and their surgical treatment is attended by serious risk.

A CASE OF TINNITUS AURIUM AND VERTIGO TREATED BY SECTION OF THE AUDITORY NERVE.—A mechanic thirty years of age had been suffering with vertigo and tinnitus for six years, and occasionally had a severe pain in back of head. All medical treatment having proved ineffectual it was decided to section the acoustic nerve of one side, and the temporal route was selected as giving better access to the internal auditory canal. An osteo-cutaneous flap was made from the squamous portion of the temporal, the dura lifted and the nerve exposed and divided at its entrance into the internal auditory canal.

The patient made a rapid recovery from the operation, but the vertigo was not cured by the interference. The author claims priority for the operation, but has little ground for advocating such a procedure in cases of that kind of vertigo, where the rationale of the operation is decidedly vague.—R. H. PARRY, *Journal of Laryngology,* August, 1904.

Miscellaneous.

Parisian Medical Gossip.

CHOLERA AND FLIES—THE ERRATIC BUT SENSIBLE VIEW OF BOUCHARD AS TO THE MOSQUITO ORIGIN OF YELLOW FEVER. HETERODOXY AS REGARDS THE STEGOMYIA FASCIATA.

(Translated by DR. T. C. MINOR, Cincinnati, Ohio)

Boucher, in a "feuilleton" in the *Journal de Médecine de Paris,* indulges in one of his characteristic diatribes, or short criticisms against his arch enemies, the pontiffs of microbiana. He remarks:

"From the far off sacred rivers of India the cholera that prevails as an endemic malady is being propagated to Europe. It follows the course of the Tigris and Euphrates, is infiltrated over the Caucasus, touches the Caspian Sea, and soon will arrive in Europe. It has descended the Volga, this terrible pestilence, and is eating at the heart of Russia."

This is a pen picture of its usual course. He continues:

Such is the painful sketch shown by Chantemesse, that eminent medical historian, depicted for the readers of the *"Matin"* as a preface for his very original (?) theory of cholera that terminates in the frightful rhetorical explosion, *"Death to the Flies!"*

The sanitary war cry of modern medical days must be added to the humorous outcry, "Death to nits, to fleas, lice, mosquitoes, and death to oysters on the half shell, the *only cause* of typhoid fever." Yes, this immortal Marseilles bacteriologist utters this vibrant note of alarm; only this and nothing more.

We shall make over the devoted head of Chantemesse the sign of of a medicinal benediction, and will not even hesitate to subscribe for a goodly sum that may be used to erect a monument to his sanitary memory; we would even subscribe for an equestrian statue to his genius if he would only rid the world of flies.

This reminds us of Boucher and of the old American, coon topical song, "Shoo-fly, don't bodder me," that rendered into very original French, might be sung to the same old tune:

Je suis, je suis, je suis,
Comme l'etoile du matin,
Je suis, je suis, je suis,
Comme l'etoile du matin,

But, the rendering of American topical, coon songs into Parisian is not very scientific—this only by way of mild digression.

Now, to continue Boucher: "But aside from this simple, personal reason for comfort's sake, the disappearance of flies from a hygienic and prophylactic standpoint, to me signifies nothing."

Even the idea emitted by Chantemesse, professor of the Paris Faculty of Medicine, the only reason upon which he does not fear to support himself, serves only as a proof of the decadence of what is termed modern medical science (Heaven save the mark!).

We should imagine, in fact, that it would be far more scientific as well as medical in all cases to investigate in an exaggeration of cause or determining causes the particular frequency of intestinal maladies and the reason for the appearance of cholera only at given epochs.

The conditions that determine, principally during the summer months, certain rapid fermentation, force on the intestinal canal, the center of this fermentation, a most fatal repercussion.

We can readily understand then that certain modifications, coming on at the proper season for fermentations, in quality, in composition or atmospheric energies modify, we know not how, but the science of the future may determine how, may give to such fermentation a deviation that is expressed in a morbid manner, sometimes by typhoid and yet, again, by cholera.

It is in this order of essentially medical ideas that we must direct our investigations. *But to seek in flies alone,* in their tiny paws, *or in the hypodermics of mosquitoes,* morbid phenomena, is lamentable, viewed from a logical medical standpoint.

Let us add that for such an eminent professor (?) as Chantemesse *it is proof of an unpardonable ignorance and defective logic.* For, finally, if Chantemesse has scientifically cultivated this question of cholera, he might have seen that the more numerous writers on its history have shown that the most deadly outbreaks have not occurred in urban communities in cities where flies abound, but in caravans, and in large armies living out in the open air, away from swarms of flies.

He might read in Collin, for example, that one of the particular characteristics of cholera epidemics was its exclusive location in certain quarters, in given houses and streets, a characteristic irreconcilable with the fly theory of contagion.

He might also see that cholera, like dengue, arrives at times at its acme on the very first onset of the malady—a particularity that again opposes this fly theory.

On the other hand, Leudet describes, and Chantemesse knows this, that in the epidemic of 1873 the contact of cholera with other patients at the Rouen Hospital, where flies abound, as in other hospitals, did not induce other cases in that house.

The same fact was evidence in the Paris hospitals during the epidemic of 1865, likewise at the Cochin Hospital as well as other public institutions during the epidemic of 1873. How, we ask, after such observations, can flies have been the vehicle of contagion?

How explain, finally, the considerable differences noted in the number attacked in the course of different epidemics of cholera observed in the same towns with this ridiculous fly theory?

These insects like mosquitoes circulate everywhere, going among all the sick, and should equalize, during epidemics, the number of cholera cases.

Moreover, we might prove by just as formidable an array of statistics the manifestations in the epidemics of 1842 and 1849, giving a mortality of 18,654 in the first of the years mentioned and in the second epoch at Paris alone of 19,184, while in 1853 there were 9,036 deaths. To the contrary, in the epidemics of 1865-66 the number of cases increased more than a third, while in 1873 the epidemic was almost nothing by comparison, there being only 855 cases. It is needful to recognize then that each cholera epidemic has a more or less special malignancy, a greater or less expansion, particular characteristics, let us add, in a word—a special epidemic genius.

But this term is in reality only a portion of the expression, for as we have so often demonstrated, cholera no more than other maladies forms an entity. Like others, it is only a result produced by a series of forces, by extrinsic or intrinsic causes.

Such are, 1st. The metereological influences described by Byder and by Cunningham, resulting doubtless in resultable planetary movements, different astral conditions, various modifications brought about in the atmosphere by the qualities of the season.

2d. Telluric inferences as indicated by Hildebrand and the great Pettenkoffer.

3rd. Influences exercised by bad social conditions in which peoples are found placed during the course of their existence; by habits of intemperance among certain nations or certain peoples.

4th. The influence exercised on *human lands* by the inoculations of ferments, the issue of animal ulcers or infectious centers, like the vaccines of Jenner and the serums of Pasteur.

Such are, in reality, some of the resultable morbid causes that, according as they are admixed in such or such proportions, give different results—typhus, plague, cholera, dengue, smallpox, tuberculosis. The problem consists then in investigating in what proportion a determined result is occasioned. Several factors must be very clearly joined in this. It is difficult, we are convinced, but not impossible, to believe then in fly paws and mosquito hypodermics.

This "feuilleton" should touch the sensibilities of that scientific body, the H. M. S., heralded by the public press of the United States as the true repressor of all epidemics. The experimental work of the Reed Commission in Cuba, that was *nothing but the repeating of the experiments of Dr. Charles F. Finlay,* the pioneer of mosquito inoculations, given out as nearly as 1881 (August 14, 1881). These experiments were stopped by the then Surgeon-General of the United States Army, on the ground that as they had already been made they were useless and cruel. That insects duly *poisoned by toxins,* as for instance flies that have fed on animals suffering with cholera, could carry malignant pustules, was a fact known for years. It was a topical deduction that anything capable of carrying the toxin of any disease might be a horrible host, but to claim that the *one cause* of *yellow fever was a mosquito of a single species* was illogical in the extreme, inasmuch that it had never been demonstrated by experiments that other varities of mosquitoes or other insects, such as flies, lice, bedbugs,etc., might not be possible hosts under the same experimental condition. The mosquito theory of malaria is as ancient as the hills. But, then, malaria occurs in winter when no mosquitoes abound.

King, as early as 1838, and Trott in 1848, were unduly exercised by the relationship between malaria and mosquitoes, and Ronald Ross, the English Army Surgeon in India, was likewise disturbed by the mosquito theory. In Louisiana, according to Dr. W. H. Duprée (See New Orleans Medical and Surgical Journal, July, 1905), there are, we are told, thirty-six species, representing eleven genera of this order of eiptera, so claims that the stegomyia fasciata is the *only one* that can be the host of yellow fever is wholly illogical until such a time as other species may be shown incapable of acting as yellow fever hypodermics. The United States Government long ago proved that by securing its garrisons pure water malaria disappeared despite the presence of the deadly mosquito (See "Malaria and Water" in Wood's Handbook of Medicine). Strange fact in viewing the inconsistency of medical theory with medical practice. Yellow fever, held to be non-contagious in times of epidemics, is rigidly treated, and rightly too, as a highly contagious disease. The patient is isolated, the household effects disinfected and fumigated, no public funerals are allowed (mosquitoes do not feast on the dead as a rule). Do all those bitten by mosquitoes have yellow fever? This question can only be solved by those erudites who maintain that the M. H. S. is the highest sanitary body of the land. With frost the fever disappears, but not the mosquito in house interiors. The stegomyia fasciata seems to avoid the colored brother in Louisiana more than in Cuba. The sweet serenador of the night, be it *psorophora in dulcet* notes, *the grahamia* the *maculipennis* that warbles so deliciously at early twilight when the "whip-poor-will is wailing to the moon," these and others might possibly act as *hosts* when poisoned by toxins and set loose from bacteriological laboratories by eminent microbian savants—but all this is digression, gentle reader, that may be pardoned in one who was never arrested for not reporting a disease that health authorities proclaimed as non-contagious. Oh, inconsistency or inconsistencies! Bouchard, after all, even with your notions as to planetary and astral bodies as distributors of mundane conditons, your notions are no more illogical than those proclaimed by public health officials. If the stegomyia fasciata is really the sole cause of yellow fever transmission, then is it highly justifiable to institute shot-gun quarantines, for mosquitoes can easily travel in a luxurious Pullman palace car or in a low down freight. When this mosquito theory once spreads all travel will cease and railroads discontinue work in mosquito weather.

The Southern Surgical and Gynecological Association.

Reported by DR. F. W. PARHAM, New Orleans.

The meeting of the Southern Surgical and Gynecological Association held at the Seelbach Hotel, Louisville, Ky., on December 12th, 13th and 14th, which we had the pleasure of attending, was a notable one in many respects. Forty-three papers were down on the programme, twenty-six were actually read, and almost without exception every paper received interesting and instructive discussion. No paper was allowed in the reading more than twenty minutes, no time being for reading in any case extended, and with few exceptions those discussing papers were confined to five minutes. All of the papers were good and most of the discussion was well digested and to the point. Altogether it was one of the most successful meetings we remember to have ever attended.

Some especially interesting papers which were heard were "Gall Stones in the Cystic Duct," by Dr. L. H. Dunning of Indianapolis, of which the special recommendation made was the dilatation of the cystic duct instead of the extraction of the gall bladder, or the removal of the stone through an incision in the gall duct; "Two Unusual Cases of Surgical Affections of the Biliary Ways," by Dr. Joseph Ransohoff, Cincinnati; "My Experience With Downe's Electrothermic Angiotribe in Pelvic and Abdominal Surgery," by Dr. J. Wesley Bovee, Washington, D. C., in which the reader stated that he had used the instrument in over two hundred cases of all sorts of abdominal operations, including ovarian, appendical and splenic excision with such emminent satisfaction that he cordially commended it to the members of the Association for trial; "An Operation for Large Rectocele," by Dr. George H. Noble of Atlanta, in which he described a new operation consisting in the pushing of the rectocele out through the sphincter ani and there ligaturing it and cutting it off, suturing the edges and letting it retract, an operation which commended the cordial endorsement of Dr. Kelly and others who took part in the discussion; "Complete Tear Operations and After Treatment," by Dr. Howard Kelly of Baltimore, in which he laid special stress upon dieting in the after treatment, which consisted in a carefully regulated regimen amounting to almost a starvation of the patient, but which he had, nevertheless, found of such signal service in the preservation of the operative results that he felt it was the most important thing that he could insist upon in the treatment of such cases. In the discussion of this paper, some agreed with him, but most disagreed, feeling that the old plan was sufficient in many cases, and that Dr. Kelly's particular plan was perhaps too unnecessarily rigid for any case. Dr. G. W. Crile of Cleveland read a paper on "The Surgical Treatment of Cancer of the Head and Neck with a Summary of 110 Cases." It was much regretted that Dr. Crile had to hurry through his paper, and had time to give practically only an abstract of this most important work of his. He recommended in all cases of epithelioma of the lip and tongue an excision begining at the clavicle below extending up to the jaw, removing the sterno-cleidomastoid muscle, internal jugular vein and digastric muscle, submaxillary gland and all excisable tissue to the level of the carotid artery. When asked in the discussion whether he meant this to apply to all cases of epitheioma of the lip, he stated he would confine excision to the tissues immediately beneath the jaw where no glands were palpable, but in all cases where any glands could be found suspicious on palpation beneath the jaw he would perform the radical operation described; asked by Dr. Ransohoff if he meant he would do this operation on both sides of the neck in cancers of the tongue where the lymphatics might be involved on both sides, Dr. Crile stated he had done this in certain cases, but had seen objections to removing the jugular veins on both sides simultaneously and he would hesitate to repeat the operation, preferring in cases where this might be required for a radical operation to decline to operate.

Dr. W. B. Coley of New York read a paper upon "Late Results of the Treatment of Inoperable Sarcoma With Mixed Toxins," in which he showed by statistics up to date that the method was still of real worth and justified further use of them in such cases. The paper of Dr. I. S. Stone, Washington, D. C., on "Retroperitoneal Myomata of Uterine Origin," elicited much spirited discussion. One gentleman in discussing this paper made the statement that he felt sure that he and other surgeons had often tied the ureter without knowing it and without the patient's subsequently becoming conscious of it, the kidney gradually atrophying and absorbing. To this statement several took exceptions in such emphatic manner that the doctor did not reply. "Goitre With a Report of 182 Operated Cases," by Dr. Charles H. Mayo, Rochester, Minn., was a very interesting and instructive paper, encouraging a more frequent resort to the extirpation of the thyroid gland; "The Surgical Treatment of Floating Kidney," by Dr. Floyd W. McRae, Atlanta, describing a new flap operation, called forth much interesting discussion. "The Diagnosis of Renal Calculus," by Guy L. Hunner of Baltimore, was an extremely interesting and valuable paper, eliciting much lively discussion. Whereas Dr. Hunner and Dr. Kelly of Baltimore maintained the value and necessity of ureteral catheterization in the diagnosis of renal calculus, Dr. Ransohoff of Cincinnati asserted with much emphasis that the ureteral catheter should have no place in the diagnosis of this condition, chiefly because the diagnosis should be made better in all cases by other means. Dr. R. E. Fort of Nashville read an interesting paper on "Laminectomy with a Report of a Case"; Dr. Robert Carothers of Cincinnati on "Varicose Veins and Ulcers of the Leg"; and Dr. G. S. Brown of Birmingham on "Fracture of the Lower End of the Femur, Operation Eight Months Afterward for Its Correction." Two papers were read on "Scopolamine Anesthesia,' the general conclusion of these papers being that, while this method of inducing anesthesia had some advantages, it was not without serious risk and should be used with great caution. Dr. Charles P. Noble of Philadelphia read a very exhaustive and critical résumé of the operation "Overlapping the Aponeurosis in the Closure of Wounds of the Abdominal Walls," which seemed in the opinion of some who discussed the paper to be a well justified claim for priority in the suggestion of this method; "Chronic Endocervicitis, a New Method of Treatment with New Instruments" was the title of an instructive paper of Dr. Daniel H. Craig of Boston. Dr. Hugh H. Young of Baltimore read his paper on "The Early Diagnosis and Radical Cure of Carcinoma of the Prostate with a Report of 40 Cases"; Dr. Rufus B. Hall of Cincinnati reported two rare and very instructive cases of "Traumatism of the Ureter and Pelvis of the Kidney"; and Dr. W. F. Parham of New Orleans read a paper reporting two cases of aneurism, one operated on by himself, of popliteal aneurism, and one operated on by Dr. E. D. Martin, on aneurism of the second and third portions of the subclavian artery treated successfully by the method of Matas.

Altogether the meeting was entirely successful and gave great satisfaction to all who were so fortunate as to be in attendance. Dr. Geo. H. Noble of Atlanta was elected President; Dr. Stuart McGuire of Richmond and Dr. E. D. Martin of New Orleans were elected vice-presidents. The next meeting will be held next December in Baltimore. The full number of members, 200, was completed by the election of new members at this meeting, with a number on the waiting list.

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,, Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

Special Meeting, February 6, 7 and 8, 1906.

The Chairman of the Committee on Arrangements wishes to announce that a reduced rate wil be procured from all railroads for members wishing to attend. This rate will probably be one fare for the round trip.

As the object of this meeting will be to discuss thoroughly yellow fever, a subject which must be of paramount interest to every resident of this State, it is to be hoped that every member who can give the Society the benefit of his experience and good advice will attend.

Papers Intended for Special Meeting.

The Committee on Scientific Work will receive papers under the following headings for the Special Meeting to be held February 6, 7 and 8, 1906:

Pathology.
Diagnosis and Treatment of Yellow Fever.
Recognition of Early (Primary) Cases.
Quarantines.
Transmission.
Etiology.
Sanitary Legislation.
Education of the Laity.

Members wishing to participate in the discussion of the above, should have the title of their papers in the hands of the Secretary no later than January 20, 1906.

THE MAY MEETING.

The following Chairmen of Sections have selected the subject for discussion:

Dr. F. M. Thornhill, Chairman of the Section on General Medicine, "Typhoid Fever."

Dr. H. Dickson Bruns, Chairman Section on Ophthalmology, "What Every Physician Should Know of Ophthalmology."

Dr. Homer Dupuy, Chairman of Section on Otology, "Laryngeal Tuberculosis: Its Early Diagnosis, Treatment and Prevention."

Dr. S. L. Théard, Chairman of the Committee on Maritime and Inland Sanitation, "Requirements of Maritime and Inland Sanitation in the Light of the Mosquito Doctrine."

Chairmen who have not already done so, are requested to send in their titles as soon as possible, so that proper announcement may be made in the next issue of the JOURNAL.

ST. JAMES PARISH MEDICAL SOCIETY.—At the Annual Meeting of the St. James Parish Medical Society, held December 8, 1905, the following officers were elected: President, Dr. B. A. Colomb, of Union; vice-president, Dr. George H. Jones, of Lutcher; secretary-treasurer, Dr. L. O. Waguespack, of Oubre. An interesting discussion was had on "Anesthesia and Anesthetics," the subject chosen for discussion, after which those present repaired to the Convent Hotel, where a sumptuous banquet was discussed by the doctors.

Medical News Items.

The Army General Hospital, which will be constructed in the District of Columbia under the authority conferred by the Act of Congress approved March 3, 1905, is designated and will be known as the Walter Reed United States Army General Hospital, in honor of the late Major Walter Reed, surgeon, whose demonstration of the mode of transmission of yellow fever is of the highest public importance. This announcement has been made by Secretary Taft.

The Portland Meeting, A. M. A., Declares a Dividend.—A dividend of 51 per cent. has been returned by the arrangement committee of the Portland session of the American Medical Association to the subscribers.

Six at a Birth.—Professor Hamy, the eminent anthropologist, has submitted a curious phenomenon to the Academy of Medicine in Paris and to the Berlin Academy. He reports that a negress living in the Gold Coast colony gave birth recently to sextuplets. Photographs were shown of the six infants, who, although they were all well formed, died shortly after their birth. This, says the professor, is probably the first time that a birth of sextuplets has been established.

The New Orleans Dispensary for Women and Children have issued their quarterly report, which shows excellent work done, there being a total number of 3,813 consultations during the quarter.

The Alkaloidal Clinic has changed its name to *The American Journal of Clinical Medicine.*

The Tri-State Medical Society on November 23d concluded a three days' session of especial interest to the large attendance. Dr. Allen Cox of Helena, Ark., was elected president; Dr. E. J. Johnson of Yazoo City, vice president for Mississippi; Dr. F. J. Runyan of Clarksville, vice-president for Tennessee, and Dr. Dickson of Pakagould, vice-president for Arkansas. Dr. Richmond McKinney was re-elected secretary, and Dr. Marcus Haase, treasurer.

THE ORLEANS PARISH MEDICAL SOCIETY elected the following officers on December 8: President, Dr. Jefferson Miller; first vice-president, Dr. John Archinard; second vice-president, Dr. E. H. Walet; third vice-president, Dr. A. C. King; secretary, Dr. A. Granger; treasurer, Dr. J. George Dempsey; librarian, Dr. Homer Dupuy; Board of Directors, Drs. G. S. Bel, J. W. Elliott and T. S. Dabney.

THE SOUTHERN MEDICAL COLLEGE ASSOCIATION recently elected these officers: President, Dr. Christopher Tompkins, Richmond, Va.; vice-president, Dr. T. H. Frazer, Mobile, Ala.; secretary, Dr. D C. Savage, Nashville, Tenn. The convention failed, after an all-day debate, to take action upon an amendment to the Constitution which would have required all candidates for admission into Southern medical colleges to have a high school education.

THE TRI-STATE MEDICAL SOCIETY OF TEXAS, ARKANSAS AND LOUISIANA met in Texarkana, December 5 and 6, electing the following officers for the year: President, Dr. Oscar Dowling, of Shreveport; vice-presidents, Dr. Luther Longino, of Minden, Dr. M. C. Thompson, of Hot Springs, Dr. R. C. Rosser, of Dallas; secretary, Dr. R. H. T. Mann, of Texarkana; treasurer, Dr. I. M. Calloway of Shreveport.

THERE WERE 452 STUDENTS registered at Tulane in December.

THE CHARITY HOSPITAL TRAINING SCHOOL FOR NURSES graduated twenty-five nurses on December 12. Dr. E. S. Lewis, the vice-president of the Board of Administrators, opened the exercises and diplomas were presented by Mayor Behrman.

THERE WERE TWO GRADUATES FROM THE SHREVEPORT SANITARIUM AND TRAINING SCHOOL December 7, Miss Josephine Dutton and Miss Daisy Hodge.

SIX TRAINED NURSES WERE GRADUATED FROM HOTEL DIEU on December 3. Dr. Ernest Lewis, the Dean of the Faculty, presented diplomas and medals to the young ladies.

MARINE HOSPITAL CHANGES.—Surgeon J. H. White has been assigned to the local Marine Hospital to succeed Surgeon Smith, with enlarged duties, and will immediately take command. The doctor is completing his final report on the fever campaign and when this is done will go off for a rest. Dr. White has made many friends during the summer's strenuous times by his tactful handling of innumerable embarrassing questions which confronted him.

PERSONALS.—Dr. A. S. Poole has been commissioned by the Governor coroner of Lincoln Parish in place of Dr. S. L. White, resigned.

Dr. A. A. Aucoin, Health Officer of Assumption Parish, was voted $650 by the Police Jury for service rendered during the past summer.

Dr. L. Edwards, of Harwich, Mass., is the Superintendent of the new State Leper Colony. There are five lepers there now.

The Governor has appointed John T. Gibbons and R. E. Craig to succeed themselves on the Board of Administration of the Charity Hospital.

Dr. A. C. Smith, who has been in charge of the Marine Hospital in this city, has been transferred to Pittsburg, Pa.

Dr. J. M. Ehlert, of New Orleans, has located at Shreveport and will be associated with the Shreveport Sanitarium.

Dr. J. M. Beauchamp has moved from Roe, Ark., to Little Rock.

Dr. U. E. G. Dyer has moved from Fort Worth to Kingsville, Texas.

Dr. B. A. Swinney has moved from Call, Texas, to Newton.

Dr. Warren S. Bickham has changed his New York address to No. 448 Madison avenue.

INFORMATION WANTED AS TO THE PRACTICAL LIVES OF THE BLIND.—Dr. George M. Gould, No. 1722 Walnut street, Philadelphia, will be grateful for any trustworthy information as to the methods which have been devised by the blind in overcoming their disability or in gaining a livelihood. Accounts of such lives, anecdotes, references to literature, etc., will be appreciated.

HISTORY OF YELLOW FEVER THROUGHOUT THE WORLD is the title of a work proposed for compilation and publication by Mr. George Augustin, Assistant Librarian of the Orleans Parish Medical Society. Mr. Augustin will have the assistance of a number of New Orleans authorities and workers in this field and his own literary experience promises well for the venture.

Recent Visitors to New Orleans.—Dr. H. S. Joseph, of Melville; Dr. George H. Jones, of Lutcher; Dr. Clarence Pierson, of Jackson; and Dr. R. L. Hagaman, of Centerville.

Married.—Dr. Anthony Joseph Montz and Miss Marie Parra on December 18. Felicitations.

Died.—Dr. O. S. McLemore of Greenwood, Miss., died at his home, aged 63, on November 23rd.

Dr. Joseph E. Thomson, of Delhi, La., died November 27th, aged 32 years. The doctor graduated four years ago from Tulane.

Dr. Edward A. Cobleigh, Dean of the Chattanooga Medical College, died on November 29, 1905. He was one of the best known among the medical profession in Tennessee.

Dr. W. J. McMurray, President of the Tennessee State Board of Health, died in Nashville on December 4th.

Obituary.—Particular sentiment is attached to the death of Dr. Garnett Barnette, who gave up his life in yellow fever work at Bon Ami, La., on October 20. The Journal is in receipt of a feeling tribute to his worth at the hands of his father—well known in this section of the State and bereaved at the great loss and trying circumstances. The Journal condoles with the bereaved and places its own emblem of regret in the memorial written to the son's honor.

The N. O. College of Dentistry, despite the panic and quarantine has a larger class than last year, numbering about 100 with brilliant prospects for the future.

A Private Orthopedic Sanitarium and Infirmary for Sick Children has been established by Dr. E. D. Fenner who is connected with this branch in the Tulane Medical School. The doctor has inaugurated the institution under ethical lines and appeals to the profession for its support.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

A Text-Book of Physiological Chemistry for Students of Medicine, by JOHN H. LONG, M. S. Sc. D. P. Blakiston's Son & Co., 1905.

This work presupposes a knowledge of the elements of general and inorganic chemistry. Together with the usual topics discussed in elementary works on physiological chemistry, an outline is given of the chemical phases of the recent theories of immunity; also, a short explanation of the important applications of the methods of cryoscopy and electrical conductivity. The beginner in physiological chemistry will find this work lucid and comprehensive. STORCK.

A Text-Book of Chemistry, by WILLIAM RUSSELL JONES, M. D., Ph. G. P. Blakiston's Son & Co., 1905.

This is another work added to an already long list of text-books on chemistry. The author says the text is based upon a system of teaching which has been successfully followed for nine years. We wish to commend the scheme of the author in commencing with simple statements and avoiding the use of technical terms until the student has acquired familiarity with his work. The references to the United States Pharmacopœia are based upon the 1900 revision. In the sections on the chemical and histological sediments found in the urine we think some of the drawings could be much improved upon.

As for the book-making in general, it is not of a very high order.

STORCK.

International Clinics, edited by A. O. J. KELLEY, A. M., M. D., Vol. I. Fifteenth Series. J. B. Lippincott Company, 1905.

This volume is particularly rich in clinical articles. In the chapter on "The Treatment of Cardiac Asthma," the reader's special attention is called to the value of small doses of morphin, 1/24 to 1/12 grain, combined with such cardiac stimulants as ether, camphorated oil, caffein. He says: "In the way of preventive treatment, much can be obtained by alimentary diet and hygiene. Let such patients avoid exposure to cold, fatigue, emotions, and alimentary excesses of all kinds; they should follow a diet in which the sodium chlorid is reduced, and should weigh themselves regularly."

He advocates the use of theobromin in 10 to 15 grain doses to be combined from time to time with digitalin. He also advises the use of Truneck's injections of serum, preparations of valerian, bromids, and even chloral.

Dr. Albert Robin, of Paris, shows sound therapeutic knowledge in his writing on "The Treatment of Cirrhosis of the Liver." The same author also writes on the "Treatment of Mucomembraneous Colitis." He says: "Enterocolitis is, in my opinion, an intestinal complication of hypersthenic dyspepsia, and sometimes of gastric fermentation. Under the influence of gastric hyperacidity pyloric spasm occurs with gastric distension, stagnation of food, and the production of fermentative acids." Further on he adds: "This new theory implies a new treatment, of which the essential point is the saturation of the gastric contents so that they be alkaline on reaching the intestine." When the intestines are induced to act regularly by means of small doses of castor oil combined with extract of belladonna and of hyoscyamus, we have found the alkaline treatment to have a beneficial effect in many cases.

"The Carbohydrates of Human Urine in Health and in Disease" is the title of an article by Dr. Carstairs Douglas of Glasgow, Scotland. The article is well written and deserves careful consideration.

The article by A. E. Gallant, of the New York School for Clinical Medicine, will well repay the reading.

The articles mentioned are only a few of the many valuable contributions to this volume.

We are pleased to see the International Clinics holding a prominent place in medical literature. STORCK.

Treatise on Diseases of the Skin, for the Use of Advanced Students and Practitioners, by HENRY W. STELWAGON, M. D., Ph. D. Fourth Edition. W. B. Saunders & Co., 1905.

This is the best exponent of American dermatology yet written. Carefully compiled, broadly discussed, the work of every dermatologist in the United States receives full credit. More than this, Dr. Stelwagon has added his experience as a teacher, and the text is prepared so comprehensively that either undergraduate student or practitioner may follow easily. In the preceding editions we have found only praise to offer, and the demand for repeated editions carries its own importance in suggestion.

Besides the natural revisions which any text requires, addtions have been made along the lines of therapy, especially light therapy. The recently described newer and rare diseases are also included in the added matter. The book should have a wide field of continued and deserved usefulness. DYER.

The Open Air Treatment of Pulmonary Tuberculosis, by F. W. BURTON-FANNING, M. D. (Cantab.). Cassell & Co.—W. T. Keener & Co., Chicago, 1905.

This is one of the monographs forming a new series of medical textbooks on Modern Methods of Treatment, rendering accessible to the general body of the medical profession the literature scattered through a number of periodicals. There is no manual serving as a practical guide in the managing of pulmonary tuberculosis that is superior to the present one. The subject is admirably presented in chapters of practical weight, with a detailed account of technic. Illustrations, paper, text and binding make of this most useful monograph an elegant book. DUPAQUIER.

Progressive Medicine, March 1, 1905. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences, edited by H BART AMORY HARE, M. D.; assisted by H. R. M. LANDIS, M. D. Lea Brothers & Co., Philadelphia and New York.

This volume, which is Vol. I. for 1905, contains the latest literature American and foreign, on the surgery of the head, neck and thorax by Charles H. Frazier, M. D.; infectious diseases, including acute rheumatism, croupous pneumonia, and influenza, by Robert B. Preble, M. D.; The disease of children by Floyd M. Chandall, M. D.; larynology and rhinology by Charles P. Grayson, M. D.; otology, by Robert L. Randolph, M. D., and index for ready reference.

Time and again in these reviews we have commended this great quarterly and fully praised it as the most indispensable companion for literary work, teaching and every day practice. We will never tire to give it the same commendation it so well deserves. DUPAQUIER.

A Text-Book of Physiology, Normal and Pathological. By WINFIELD S. HALL, Ph. D. (Leipzig). Second Edition. Lea Bros. & Co., 1905.

Considerable revision has been applied to this work since the first edition and it still commends itself for the practical and logical arrangement of the matter contained.

Pathologic physiology has been particularly brought forward and the chapters devoted to the separate tissue functions are noteworthy. This must continue a valuable text-book and reference work. DYER.

A Handbook of Nursing. Revised Edition. Published under the Direction of the Connecticut Training School for Nurses. J. B. Lippincott & Co., 1905.

This is a practical treatise for the trained nurse, covering almost every particular which affects the occupation of the training school graduate.

The illustrations are few but judicious. DYER.

Essentials of Diseases of the Skin, by HENRY W. STELWAGON, M. D., Ph. D. Sixth Edition. W. B. Saunders & Co., 1905.

This standard text has been revised, especially in the matter of illustrations and changes necessitated by the advances in dermatology. Since the issue of the first edition over 40,000 of this text have been sold, attesting its widespread popularity. DYER.

Hygiene and Public Health, by B. ARTHUR WHITLEGGE, C. B., M. D., B. Sc., F. R., B. P., D. P. H., and by GEORGE NEWMAN, M. D., D. P. H., F. R. S. E. New Edition. W. T. Keener & Co., 1905

Hardly any subject relating to public health has failed of notice in this work. Foods, ventilation, habitations and sanitation are considered and large space is assigned to particular diseases and conditions. Quarantines, water supplies and public sewerage disposal are also treated of. An unusual care is evidenced throughout in presenting the subject so that a lay reader may profit by studying this work, while the specialist in sanitation will find it a ready guide. DYER.

A Text-Book of the Practice of Medicine, by HOBART AMORY HARE, D. D., B. S. Lea Brothers & Co., Philadelphia and New York, 1905.

A text-book from Hare is always welcome. It reflects the long experience of a gifted teacher who takes hold of every opportunity to improve his teaching. Constantly in touch with students and with the new developments in medical science and practice, he is able to build a text-book for usefulness, replete with the needs and wants of both the undergraduate and the practitioner of the present day. Conscientious to the core, in producing a useful book he seeks advice on certain subjects from those whose opportunities have been turned to special knowledge. Thus, among other features of the present book, there is a number of chapters on Tropical Diseases, written by Dr. C. F. Kieffer, Major and Surgeon in the United States Army, after his return from service in the Philippines.

DUPAQUIER.

Addresses and Other Papers, by WILLIAM WILLIAMS KEEN, M. D., LL. D., F. R. C. S. (Hon.) W. B. Saunders & Co., 1905.

It has been the pleasure of many of us to read the occasional article, address or lecture of Dr. Keen, and it is a matter of congratulation that he has found a publisher who realizes that many of the profession will be glad to review the work of our friend and teacher in extenso. It is just such published memoirs which make the record of medical achievement individual.

DYER.

The Development of the Human Body, by J. PLAYFAIR MCMURRICH, A. M., Ph. D. Second Edition. P. Blakiston's Son & Co., 1905.

This text is unusually clear and deals essentially with embryonic development of tissue and of the human body. The illustrations are numerous, original and especially explanatory of a most excellent context. No one chapter excels, while the work, altogether, stands for an exact and careful presentation of a difficult subject.

DYER.

The Practitioners' Visiting List (heretofore known as the *Medical News Visiting List*) for 1906. Lea Brothers & Co., Philadelphia, 1906.

This popular visiting list is making its annual appearance and bid for patronage. It is presented in the weekly, monthly and perpetual editions. It is presentable, has the usual tables of information and is in every way creditable.

The Physicians' Visiting List for 1906. P. Blakiston's Son & Co. Philadelphia.

For the fifty-fifth time this old friend makes its timely appearance. The visiting list proper is preceded by valuable tables. It is presented in the regular, the perpetual and the monthly edition. It is bound in black leather, as usual, and is in every way convenient.

Organotherapy, by H. BATTY SHAW, M. D., F. R. C. P. W. T. Keener & Co., Chicago.

This is a small treatise on the treatment of disease by means of preparations of various organs. It is divided into five sections. The first is devoted to the study of the thyroid and parathyroid glands, and includes their anatomy, physiology and pathology, as well as their therapeutic use. Section two refers in a similar manner to the suprarenal glands. Section three takes up the alimentary tract, including the pancreas and liver. The glands of the genito- urinary system take up section four. while the last section considers other organs and tissues which are less known and as yet are of more restricted use.

Of course, this volume of some 250 pages can only treat a subject of such growing importance in an elementary way, but it is useful as a summary of our knowledge on the subject and, in itself and by means of the numerous references with which it abounds, can be very useful to all those iterested in preparations derived from the various organs of animals

C. C.

Atlas and Epitome of Diseases of the Skin, by DR. FRANZ MRACEK. Authorized translation from the German. Edited by HENRY W. STELWAGON, M. D., PH., D. Second Edition. W. B. Saunders & Co., 1905.

Colored plates of diseases of the skin must be remarkably well made to be of any service, as the attempt to imitate the colors in nature's plan is a difficult task. Of the atlases within the reach of the average practitioner this is one of the best, especially as some of the more unusual diseases of the skin are well presented. The text is especially clean.

DYER.

The Ready Reference Handbook of Diseases of the Skin, by GEORGE THOMAS JACKSON, M. D. Fith Edition. Lea Bros. & Co., 1905.

The points of particular excellence in this work are the clear definitions and the concise descriptions. The alphabetic arrangement, still maintained. must always appeal to the busy practitioner, who is saved the cross references usually necessary in group arrangement of the diseases. The plates are mostly good, but quite a number are no longer clear, and might be retired. The revision of the text is evident in many places, and the work fulfills its title in every respect. DYER.

Publications Received.

W. T. Keener & Co., Chicago, 1905.

Hygiene and Public Health, by B. Arthur Whitelegge, M. D.
Clinical Methods. Hutchinson-Rainy.
A Manual of Chemistry. Luff-Page.
Organotherapy, by H. Batty Shaw, M. D.

P. Blakiston's Son & Co., Philaelphia, 1905.

Biographic Clinics, by George M. Gould, M. D., Vol. III.
Postoperative Treatment, by Nathan Clark Morse, M. D.
Text-Book of Medical and Pharmaceutical Chemistry, by Elias H. Bartley, M. D.

Lea Bros. & Co., Philadelphia and New York, 1905.

The Principles of Bacteriology, by A. C. Abbott, M. D.
Text-Book of Practical Therapeutics, by Hobart Amory Hare, M. D. 11th Edition.
Manual of Chemistry, by W. Simon, Ph. D., M. D.
Pathogenic Micro-Organisms, Including Bacteria and Protozoa, by William Hallock Park, M. D.
Progressive Medicine. Hare-Landis. December 1, 1905.
Minor and Operative Surgery, Including Bandaging, by Henry R. Wharton, M. D.
Surgical Diagnosis, by Albert A. Berg, M. D.
Physical Diagnosis, by Egbert LeFevre, M. D., 2d Edition.

F. A. Davis Co., Philadelphia, 1905.

Operative Surgery, by John J. McGrath, M. D. 2d Edition.

Lectures on Auto-Intoxication in Diseases, or Self-Poisoning of the Individual, by Charles Bouchard; translated, with a preface and new chapters added, by Thomas Oliver, M. D. 2d Edition.

E. B. Treat & Co., New York, 1905.

Disorders of Metabolism and Nutrition, by Dr. Carl Von Noorden, Part VII.

Diabetes Mellitus.

Neurotic Disorders of Childhood, by B. K. Rachford, M. D.

Sexual Neurasthenia, by George M. Beard, M. D.

The McMillan Co., New York and London, 1905.

Surgical Aspects of Digestive Disorders, by James G. Mumford, M. D., and Arthur K. Stone, M. D.

J. B. Lippincott Co., Philadelphia and London, 1905.

International Clinics.. Vol. III, 15th Series.

Genito-Urinary and Venereal Diseases. White-Martin. 6th Edition.

MISCELLANEOUS.

Communication to the Hospitals of Greater New York by the Committee on Hospital Needs and Hospital Finances, November 1, 1905.

Digest of Latest Published Reports of Hospitals Manhattan and Bronx, by the New York Association for Improving the Condition of the Poor.

Department of Health of the Isthmian Canal Commission for the Month of May, 1905. Col. W. C. Gorgas.

Memoirs of the National Academy of Sciences. Vol. X. (Government Printing Office, Washington, D. C.)

Laboratory Guide in Experimental Pharmacology. Edmunds-Cushny. (George Wahr, Publishers, Ann Arbor, 1905.)

Baby Incubators, by John Zahorsky, M. D. (Reprinted from a Series of Articles in the *St. Louis Courier of Medicine,* 1905.)

Life Insurance. The Abuses and the Remedies, by Louis D. Brandeis. (Published by the Policy Holders Protective Committee, Boston, 1905.)

Cleft Palate and Hare Lip, by W. Arbuthnot Lane, M. D. (The Medical Publishing Co., Ltd., London, 1905.)

Reprints.

The Care and Treatment of the Urinary Function in Locomotor Ataxia, by Dr. George S. Whiteside.

Epilepsy, by Dr. John W. Selman.

Method of Administering Mercury in Syphilis, by Dr. Otto Lerch.

A Further Contribution to the Study of Pruritus Ani, With Special Reference to Its Local Treatment; (2) *A Consideration of Some of the Methods for the Treatment of Cancer of the Rectum;* (3) *Internal and External Hemorrhoids;* (4) *The Treatment of Internal Hemorrhoids by the Injection Method;* by Dr. Lewis H. Adler, Jr.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR NOVEMBER, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	2	3	5
Intermittent Fever (Malarial Cachexia)	1	4	5
Smallpox	......	......	......
Measles	......	......	......
Yellow Fever	6	......	6
Whooping Cough	......	......	......
Diphtheria and Croup	3	1	4
Influenza	3	......	3
Cholera Nostras	......	......	......
Pyemia and Septicemia	3	3	6
Tuberculosis	36	44	80
Cancer	21	8	29
Rheumatism and Gout	1	1	2
Diabetes	......	......	......
Alcoholism	3	2	5
Encephalitis and Meningitis	6	......	6
Locomotor Ataxia	......	......	......
Congestion, Hemorrhage and Softening of Brain	21	6	27
Paralysis	7	1	8
Convulsions of Infants	4	5	9
Other Diseases of Infancy	14	8	22
Tetanus	4	4	8
Other Nervous Diseases	1	......	1
Heart Diseases	39	29	68
Bronchitis	3	3	6
Pneumonia and Broncho-Pneumonia	20	13	33
Other Respiratory Diseases	3	1	4
Ulcer of Stomach	......	......	......
Other Diseases of the Stomach	......	......	......
Diarrhea, Dysentery and Enteritis	14	8	22
Hernia, Intestinal Obstruction	2	......	2
Cirrhosis of Liver	5	1	6
Other Diseases of the Liver	4	......	4
Simple Peritonitis	1	......	1
Appendicitis	2	1	3
Bright's Disease	32	20	52
Other Genito-Urinary Diseases	4	1	5
Puerperal Diseases	7	1	8
Senile Debility	24	6	30
Suicide	1	......	1
Injuries	20	17	37
All Other Causes	16	11	27
TOTAL	333	202	535

Still-born Children—White, 18; colored, 28; total, 46.

Population of City (estimated)—White, 236,000; colored, 89,000; total, 325,000.

Death Rate per 1000 per annum for Month—White, 16.72; colored, 27.23; total, 19.75.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	30.09
Mean temperature	65.
Total precipitation	3.62 inches.

Prevailing direction of wind, north.

New Orleans Medical and Surgical Journal.

VOL. LVIII. FEBRUARY, 1906. No. 8

Original Article.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

Points on Treatment of Abdominal Arteriosclerosis—Outline of Treatment of Blackwater Fever.

Summary of a lecture at the N. O. Polyclinic

By E. M. DUPAQUIER, M. D.
Prof. of Clinical Therapeutics and Tropical Medicine in N. O. Polyclinic.

GENTLEMEN:—This out-door clinic, while it is yet limited in size of material, has, nevertheless, afforded us a variety of cases which as to quality have repaid us for the lack of heavy records as to quantity.

We have had the opportunity to clinically examine here, cases of:

Miliary tuberculosis.

Diphtheria, of which two cases were injected with antitoxin, right here.

Cholera infantum, of which two cases, also, were injected with antidysenteric serum, right here.

Colitis with amœba, confirmed by microscopical examination, injected with quinin solution per rectum, right here.

Pleurisy with large effusion, tapped according to the siphonage method, right here.

Bronchial asthma in a youth, successfully treated with tartar emetic, only.

Aneurism of the aorta, of which one case dying at the Charity Hospital, the specimen was secured at autopsy and is here on exhibition when needed.

Unusual systemic manifestations of malaria, also of syphilis and gonorrhea, of which most cases were referred to special clinics, but some retained to demonstrate a point or two, such as, for instance, the advantages of the Gottheil treatment.

Valvular disease, chiefly aortic regurgitation, one of which presented a remarkable musical murmur and another a distant so-called Durosiez' sign.

Arteriosclerosis in its various manifestations, cardiac, renal and gastro-intestinal, the latter being again considered today, as we have a good case here.

This man before you now, is forty-three years old, but looks fifty. A painter by occupation from the age of eighteen to thirty years; idle and living high from the age of thirty to forty years, squandering inherited money, he now applies for relief of some abdominal complaint, for which surgical interference has been repeatedly suggested and offered.

He has attacks of severe pain in the pit of the stomach, radiating to the liver, vomiting with flatulence, colic with diarrhea alternating with constipation as if his bowels were occluded. He now weighs 110 pounds; he weighed 165 three years ago.

Before coming to the clinic, he was told he had an ulcer of the stomach, a cancer of the stomach, gall-stones and a cancer of the intestine, and truly the symptoms are very suggestive in that direction.

But the fact must not be overlooked that this man has had in his life enough of the factors that "age" man: plumbism, high living, alcoholism and worry combined. These have certainly told on his arteries. Indeed, most of the signs of diffuse arteriosclerosis are present. The sphygmomanometer which I have already used in your presence indicated lately 190 mm.

After considering the differential diagnosis carefully, I take it for certain that this man's abdominal complaint is referable to arteriosclerosis.

In Schlesinger's list of internal diseases liable to surgical treatment, which, I have often remarked, you should always bear in mind, the diseases of the stomach, liver and intestines occupy, and justly so, a prominent place. But, in a case like this one here, in spite of the indications, beware. Arteriosclerosis is so evident, above all other things, that marked localized arteriosclerosis, as autopsies show, probably accounts for the abdominal manifestations. Therefore be careful in your decision for treatment in such cases. Do not refer the case to a surgeon for operative treatment before calling a surgeon "qualified to do good abdominal surgery" in consultation. And it were better for all concerned, the patient, the consultant and yourself, if the hygienic, dietetic and medicinal treatment of arterial disease, upon which I have already laid so much stress, were first strictly applied and properly carried out.

Requested to give an outline of the treatment of blackwater fever, I will gladly do so and give you the best information at my command.

I am told by one of you from a Louisiana parish that "more cases die than get well." The same complaint comes from many other practitioners treating this fever. From good authority I understand that as a rule overtreatment is indulged in, and this proves fatal just as in yellow fever, pneumonia, typhoid and many other infectious diseases against which we have no specific.

We see but very few cases here in the city or in its close vicinity, very few apart, and those I have seen were all imported; they originated elsewhere, in our State, in Arkansas, Texas, Colombia, South America. Only one being a native, the others Sicilians and Germans. They all gave the same history, viz.: periodical attacks of malaria, insufficient treatment, previous attacks of blackwater.

At the time I treated them, only one had quinin by needle. The others had no quinin at all, either by needle, mouth or rectum. The quinin was given after the appearance of the blackwater and did not seem to have had any effect in shortening the duration or the severity of the febrile attack and blackwater. They were transient cases and I have lost sight of them since.

But, from all reliable sources, from those competent and experienced medical men who treat a large number of such cases, if no new work, advance or discovery is heard, that much is more firmly established that the great majority concur in the same ideas of treatment at present, viz.: Quinin is useless and harmful. Useless during the attack, harmful before the attack. It is most commonly the cause in those suffering from periodical attacks of malaria insufficiently treated. Bastianelli's old formula to give quinin only when malaria parasites are found in the blood remains still a SAFE guide, since from the latest authoritative statements we understand that parasites are found only in a FEW cases, not EVERY case as some say.

There is no substitute for quinin, including methylene blue and the cassias. There is no drug of value against blackwater fever. The symptoms must be met the best we can. The use of "styptics" is unpardonable. I understand from reading competent statements that the cases must be treated pretty much as we treat yellow fever here, viz.: Confinement to bed, at once; recumbent position far into convalescence; warm water draughts with sod. bicarb. in them as an emetic to get rid of irritating bile causing exhausting vomiting.

If the stomach is settled patient must take five grains of calomel and then start drinking water freely to keep the kidneys flushed, while hot fomentations and turpentine stupes are applied to the loins to relieve pain and prevent suppression. Patient must be fed with orange juice, barley water, oatmeal water, lemonade, and if that is retained, milk and broth. Alcohol is not necessary, except in weak patients. All the while the patient is disturbed as little as possible, carefully sponged with tepid water every two or three hours.

If the stomach is not settled after the emetic, instead of calomel, give irrigation of the colon. Give water and food by rectum. Inject under the skin an abundance of normal salt solution and trust in God or in the patient's ability to fight it out, with that, and it is all that you can do, intelligently.

But, in the light of modern advanced treatment, for as slow as it is it advances, you can to a great extent prevent the sad occurrence of blackwater by completely eradicating at the outset the malarial infection by systematic acclimization, just as you could prevent the later severest manifestations of syphilis by a thorough and systematic mercurialization at the onset.

The "district" of habitation is an all-important matter of course, and the district must be "evaded" until the anopheles with sporozoëttes are destroyed and the inhabitants in that district take to "screening" first, which means a great expenditure of care, time and money. Finally, as to the hemoglobinuria caused by exposure to cold, or by violent physical exertions, it is not quite definitely understood and doubt arises as to the value of these causes. Look upon blackwater as an infectious disease, malaria plus something else, unknown, and you will be safely guided in both your prophylactic and actual treatment.

Louisiana State Medical Society Proceedings.

(Edited by Publication Committee).
P. L. Thibaut, M. D., Chairman.

Dr. E. L. McGehee read a paper entitled:

"Report of Two Cases of Ovarian Cyst, with Twisted Pedicle."

Case No. 1: I was permitted, through the courtesy of Dr. P. B. McCutchon, of this city, to see this case, a lady, age forty-two, suffering with pains in the right iliac region and unable to empty her bowels. This was at a monthly period, yet her menstrual history had been normal.

There was no temperature, but vomiting and great prostration were prominent symptoms.

Being unable to overcome the obstruction of the bowels, it was deemed necessary to open the abdomen. As her husband was absent, the operation was delayed thirty-six hours. During this time the abdomen became distended, with distinct tumefaction on right.

Was this obstruction due to appendicitis? The nausea, vomiting, pain and tumor did simulate it. Was it due to peritonitis, with constricted bowels? Was volvulus or strangulation the cause? Or could this be intussusception? There was no rectal tenesmus with passage of bloody mucus.

Such were the interrogations that received consideration.

The patient entered Touro Infirmary on November 5, was operated on the 7th and returned to her home on the 24th of the same month.

Upon opening the abdomen, by median incision, a large, liver-colored soft tumor was seen occupying the right iliac and most of the right lumbar region, extending to the median line. This proved to be an ovarian cyst that had turned several times on its axis, shortening the pedicle and causing the tumor to press a coil of the intestines firmly against the posterior wall, thus effectually obstructing the bowel. The removal of the cyst removed the obstruction and was followed by uninterrupted recovery.

Case No. 2: Miss M. H., a young teacher, about twenty-two years of age, spare, tall and well built, with good family history (every sign of pure life), sensible, sensitive and with self-control. She was active, climbed steps, played lawn tennis and took other exercise, without knowledge of any pelvic trouble, except dysmenorrhea the first two days of each period.

On Saturday, at the proper time, her menstrual flow began. As the pain was unusually severe, an opiate was given her, which relieved her so that I was not called until Monday. There was fever and pain, with rigidity of muscles, yet no well defined swelling was present on the left side.

Purgatives were administered and ice-bag applied over site of pain. Fever and pain were not diminished, and tumor was perceptible, apparently the size of an orange, the next day. She was removed to Touro Infirmary March 27, 1905. Pelvic examination revealed hymen intact, normal uterus and no indurated pelvic exudate, but a distinct ovoid mass, easily palpated in the left iliac region. Pulse became more rapid each day. Patient became pale, as if she had lost blood, and fever continued, ranging from 101 to 102. Bowels moved freely, yet tumor increased in size. Being conscious of the gravity of the situation, though far from her family, she bravely consented to the operation when it was proposed. It was necessary that the incision be extended two inches above umbilicus, from the symphysis, in order to remove the tumor without rupturing it. It was as large as the uterus at five months' gestation, soft, dark and adherent to anything it touched. The fresh, easily broken exudate completely filled the pelvic wall.

After tying and removing, the cyst—a par-ovarian cyst as large as a hen's egg—was dissected from its attachment to the right Fallopian tube, agreeable to the custom of many, as we thought it best not to let the appendix escape. When the colon on the right side was lifted, the sigmoid flexure and not the cecum was at end of colon.

It was the descending colon that had been pushed by the rapidly growing tumor over to the opposite side of the abdomen and had become fixed by peritoneal inflammation. These were broken up and viscera placed in normal position, the cecum bared and appendix removed. It was unusually long.

It was well we looked for the appendix or obstruction would likely have resulted from the abnormal relation of bowel and adhesion present.

In ten days (April 5), our patient returned to her college, without having any pain or temperature after the operation. She was in the sanitarium (Touro) only nine days.

The cysts and appendix are before you, gentlemen of the Louisiana State Medical Society, for inspection, which show the large dark tumor to be a thin sac filled with blood and serum.

The frequency of torsion of the pedicle and its gravity justify the report of these two cases, for early diagnosis and prompt operation are imperative.

Thornton found 57 in 600 cases of ovariotomy. The first report of cases was in 1865. Much speculation has been resorted to to determine the cause of axial rotation.

Descending masses of fecal matter (Tate), changing position from back to side, or when pressed on by costal cartilages above and pelvic strictures below. Sudden change of position in playing lawn tennis seemed to have been the determining cause in last case. There was enormous increase in the volume of the growth and acute pain. From Monday tenderness in the left iliac region. No distinct tumor on Thursday, when it was removed, it was so developed as to require incision in abdomen to be carried about umbilicus. Extreme pain was present. The bowels moved thoroughly and ice-bag was constantly applied. The rapid growth and turgescence is due to the transudation of sanguiferous elements into and upon tumor. The arteries take the blood to the cyst, but torsion prevents the thin-walled veins from removing it. The newly-formed adhesions were extensive, the descending colon was displaced to right side and when the appendix was felt for, the sigmoid and cecum were at end of colon we had in hand. The pelvic wall and its viscera were lined with fibrous exudate. The distensibility of the sac is a source of surprise. The blood pressure would induce cell necrosis but for nutrition derived from adhesions. The patient had no knowledge of the existence of a cyst, yet with great pain and rapidly growing tumor and considerable shock, the diagnosis was confidently made.

Reed frankly confesses that we do not know the cause of ovarian cyst. The following causes are merely speculative: Menstrual congestion, hereditary predisposition, chlorosis during puberty (Scanzoni).

Olshausen states they are rare in childhood. I remember seeing one removed from a girl eleven years of age by Dr. A. B. Miles. The girl had not yet menstruated.

I would like to hear from Dr. E. S. Lewis on this point. He has had more gynecological experience than any other man in the South. Recent investigation shows that ovarian and par-ovarian cysts are much more frequent than commonly supposed. Par-ovarian cysts are often associated with ovarian cysts and with ovarian disease of same or opposite side.

Minute anatomy shows that par-ovarian cyst to consist of a number of small closed tubercles, running transversely in a fan-shaped arrangement from the ovary toward the Fallopian tube (Quain and H. C. Coe), lined with cylindrical and sometimes ciliated epithelium.

DISCUSSION.

DR. CLARK: I recall having an interesting case of twisted ovarian cyst. The woman was seen by me about 12 in the day, when she complained of acute pain in the abdomen. She had a temperature of 100°. Upon examination of the lower central portion of the abdomen, it simulated in appearance that of a case of distended bladder. The abdomen was rigid and tender. Combined with the history and finding, the uterus pressed back on the rectum, the diagnosis of twisted ovarian cyst was made. This case illustrates the importance and value of making a rectal examination in all gynecological cases, and in this case the diagnosis was chiefly made through the digital exploration of the rectum.

DR. MILLER: I believe that it is generally considered now that we have about ten per cent. of twisted pedicles in these cases of cyst. More of this occurs about the time of labor than any other time. If there is a case of ovarian cyst of lengthy pedicle, you are very likely to have trouble at that time.

A woman came to me who had been delivered about six months previously by the midwife. I opened the abdomen and found the pedicle attached to one of the tubes and the ligament, and it looked to be at least twelve inches in length. It must have been anchored there after delivery.

DR. MCGEHEE (In closing): An early diagnosis is very important, and it is very easy to overlook this condition.

As to why the pedicle should turn in this manner, I do not know, although several explanations have been offered. Some say one thing, and others say others.

AFTERNOON SESSION, MAY 10, 1905.

SECTION ON MEDICAL JURISPRUDENCE.

DR. A. L. METZ, Chairman, read a paper on *Modern Embalming, Considered from a Medico-Legal Standpoint.*

(Paper not furnished to Publication Committee.)

DR. E. D. FENNER read a paper on:

"Pneumonia in Childhood."

There are three varieties of pneumonia seen in the young: 1. Broncho-pneumonia. 2. Lobar pneumonia. 3. Interstitial pneumonia. The first two are very common; the last rather frequent, and not often recognized.

Some idea of the frequency of pneumonias in early life may be gotten from the statistics of the New York Infant Asylum, compiled by Holt. During eight years there were 726 autopsies. Of these, 322 were pneumonia cases. They are tabulated as follows:

Pneumonia:

Primary	139
Secondary to acute infectious diseases	112
Complicating other conditions	71

For comparison, gastro-intestinal diseases furnished:

Acute entero-colitis	116
Acute diarrheas, without inflammatory lesions	72
Cases with purely gastric symptoms	0

Jno. Lovett Morse (*Archives of Pediatrics*) reports that at the Children's Hospital, in nine years, there were 1,900 cases of labor pneumonia, of which fifty were in children in their first year and sixty-eight in the second year. During the same period sixty cases of broncho-pneumonia were treated. In this connection he calls attention to the fact that in all probability many mild broncho-pneumonias were not admitted to the hospital, and that no cases of broncho-pneumonia secondary to the eruptive diseases (and these must have been numerous) were eligible to the wards. This accounts for the relatively small number of broncho-pneumonias in his table.

In regard to the relative frequency of the two ordinary varieties of pneumonia in childhood, we must not be led astray by such statements as "broncho-pneumonia is the pneumonia of childhood." This should be taken to mean that broncho-pneumonias are NOT the pneumonia of adult life, rather than that it is the only doom to be expected in infancy. In truth lobar pneumonia is very frequent in the young. At the New York Infant Asylum, in children under five years of age, there were 261 cases of broncho-pneumonia, and 109 of the lobar form. Taking the cases occurring in the first two years of life only, 75% were broncho and 25% lobar pneumonia.

There are some general factors in the etiology of pneumonia in childhood which afford a marked contrast in the two forms of the disease, viz.:

1. *Age* is without doubt a potent factor as a predisposing cause

of pneumonia. The anatomical and physiological peculiarities of the respiratory apparatus would lead us to expect a decided influence on the frequency, course and prognosis.

These peculiarities are briefly: The cartilaginous and yielding nature of the ribs; the imperfect development of the muscles of respiration; the relatively large proportion of interstitial tissue, and the great area of the bronchial area as compared to the parenchyma or air vesicles; the actual (not relative) smallness of the bronchi, particularly the terminal ones; the loose attachment of the mucous membrane to the underlying bronchial wall and the tortuousness and large size of the blood vessels beneath the membrane, so that congestion readily produces obstruction to the inflow of air to the lobules of the lung. These conditions all tend to interfere with the movement of air in and out, and taken in conjunction with the well known tendency in all inflammatory affections in infancy to *cellular* exudation, are certainly active predisposing causes of the development and spread of pneumonia whenever the bronchi or lungs become congested.

Four hundred and twenty-six cases of broncho-pneumonia examined into by Holt were distributed as follows:

During the first year......224 cases or 53%.
During the second year.....142 cases or 33%.
During the third year...... 46 cases or 11%.
During the fourth year.... 10 cases or 2%.
During the fifth year....... 4 cases or 1%.

Of 500 cases of lobar pneumonia he found:

During the first year 76 cases, or 15%.
From the second to the sixth year 39 cases, or 62%.
From the seventh to the eleventh year 104 cases, or 21%.
From the twelfth to the fourteenth year 11 cases, or 2%.

2. *Sex.* In both lobar and broncho-pneumonia there seems to be a preponderance of males, amounting to 10%.

3. In both types season has an important bearing, about 70% of the cases occurring during the winter and spring months.

4. The social condition and surroundings of the child are undoubtedly a factor in pneumonia. Bad sanitary conditions, poor feeding, crowding, and careless nursing are responsible for a lowered vitality which must predispose to pneumonia.

5. Exposure to cold and sudden chilling cannot be disregarded in the etiology of pneumonia.

6. And lastly, the micro-organisms, which are the specific cause, must be remembered, although I shall not attempt to discuss their relations to the various forms of pneumonia.

As to the location of the disease in lobar pneumonia, Morse, Holt, and practically all other writers agree that in order of frequency, we have: 1, the left base; 2, the right apex; 3, the right base; 4, the left apex; 5, the right middle lobe.

Morse's table gives: Right upper lobe, 20 cases, or 17%; right lower lobe, 19 cases, or 16%; left upper lobe, 16 cases, or 14%; left lower lobe, 45 cases, or 38%; right middle lobe, 1 case, or 1%.

It should be remembered that in searching for pneumonia in the young, the region high up in the axilla never should be overlooked. As to the symptoms and diagnosis of pneumonia, important as they are, I shall say little. Frank, typical cases are very easy to recognize. But unfortunately all cases are not of this outspoken type. Many are obscure, with doubtful symptoms, and physical signs so obscure as to be almost impossible to distinguish. In this connection, W. P. Northrup (*Chicago Med. Recorder,* November, 1904) says: "Early manifestations sufficing for a diagnosis are: 1, sudden onset, with fever and dopiness; 2, rales; 3, disturbance of the respiration; 4, pulse ratio. Whenever the respiration pulse ratio departs from the normal 1-4, and approximates 1-3, keep looking for pneumonia. A better rule in any obscure illness is to keep looking for pneumonia all the time."

The young and inexperienced practitioner is too often led astray by the peculiar puerile respiration of infancy, being deceived by the diminished respiratory murmur over an area of consolidation, and the exaggerated breath sounds on the other side into diagnosing pneumonia in the healthy but over-acting lung. Again, the insidious onset of pneumonia in the course of some exhausting disease, such as an entero-colitis, is frequently attended by such slight additional symptoms that it is never suspected till death is at hand.

The mortality of lobar pneumonia is very much lower than that of broncho-pneumonia; the former, being generally primary and attacking the robust child, is acute, sthenic, self-limited, and in a large proportion of cases terminates in recovery. Broncho-pneumonia, on the other hand, so much more often a complication of some acute infectious disease, and selecting by preference the feeble and debilitated, is longer in duration and very fatal. I find it difficult to accept the statements of those who "have never lost a case of pneumonia." Such is not the experience of men of the widest experience and highest reputation. It is very certain, however, that the mortality of private cases is very much lower than that of institutions. It is true of pneumonia and of many other conditions in the babe, that the patient often dies of the hospital after getting over the disease. Hospitalism is a factor well recognized by pediatrists.

When we arrive at the treatment of pneumonia in the young we must admit that our resources are not much better than those of our predecessors. From time to time, various remedies have been lauded as specifics, but one by one they have been shown to be useless. Like most other observers, I do not believe we have any specific which will cut short a pneumonia. Creosotal in recent years, has been recommended with enthusiasm. Van Zant (*Med. Record,* October 18, 1902) states that "Thirty-seven physicians report 762 cases of all ages (adults and children) and consider that it *sometimes* aborts pneumonia; fifteen report 187 cases and consider that it does not; fifty-seven report 1,022 cases and consider that it renders the course of the disease less severe. This was at the height of the popularity of creosotal, and today the opinion would probably be less optimistic. We must not forget, too, that pneumonia sometimes aborts itself. Personally, I must confess that I still cling to the use of creosotal in the hope that it may do some good, but that I feel little real confidence in its powers. The theory that it exerts a remote local action, and disinfects as it is being excreted is so attractive that it is hard to discard it without a sigh of regret.

The treatment of pneumonia, then, is symptomatic. As Jacobi tersely puts it, "the patient is to be treated, and not the Greek name of the disease."

Prophylaxis requires that every case of bronchitis should be carefully attended to, lest pneumonia result. Isolation of pneumonia should be practiced wherever possible. Heubner, the Professor of Pediatrics at the University of Berlin, is convinced that he has greatly reduced the mortality of pneumonia, complicating the infectious diseases by erecting screens of glass between the beds in the infectious wards of the hospital.

The importance of plenty of fresh air cannot be overestimated. Northrup has emphasized this when he said that in the near future he believed that a free flow of fresh air "would be considered one of the most important drugs in pneumonia."

Frequent change of position is important to prevent stagnation of the blood in one part of the lungs. A certain amount of *mothering* is helpful for this and for its effect on the baby's spirits. I have seen quite young infants die of grief and homesickness when placed in an asylum. The care of the digestion and nourishment must be anxious and constant. The only way the excessive combustion can be compensated for in pneumonia is by good absorption. Moreover, the effect of a distended belly is easily seen in the embarrassment of the breathing.

Of the individual symptoms, the fever is the one we are most apt to feel like attacking. Jacobi very wisely remarks that "unfortunately the thermometer alone, ranging from 103 or more, is often permitted to establish indications, and reduction of temperatures appears to become a fad, and the whole duty of many practitioners." Again, "Phenacetin and its congeners have reduced more temperatures than they have saved lives." These are wise words. The temperature of pneumonia does not do much harm unless it is excessive. Long ago I abandoned the use of antipyrin, having seen it produce dyspnea and cyanosis in the hands of others. Phenacetin in small doses, and not too often, not only reduces fever, but quiets the nervous system, and is, therefore, sometimes indicated. The fever of pneumonia can be largely let alone when it is moderate in range and is not producing symptoms of nervous disturbance. Where antipyretic measures are needed, hydrotherapy is the best. Water may be used as the bath, by sponging, or in the form of the pack, or cold may be applied in the form of ice-bags. Of the latter it may be remarked that infants do not stand the ice-bag to the head, in a good many cases being shocked and depressed by its continued application. Of the bath, sponge and pack, sometimes one and sometimes the other is grateful and efficient. The choice must be made after trial. Cold water is indicated when the circulation is active and the heart strong. But when the extremities are cold and the bath is followed by prostration, shivering, and the extremities remain cold, it is contraindicated and should be abandoned. Remember that in these cases, when there is nervous disturbance, a *hot* bath may bring the blood to the surface, and be followed by marked reduction of temperature.

I am quite convinced that local applications are generally useless in pneumonia. Great, soggy poultices, such as we used to employ constantly, weighting down the tired muscles, cannot be comfortable or helpful. Antiphlogistin, I firmly believe, does more good to the mother than to the child, and immobilizing the chest by a couple of plaster strips should give more relief to pain and dyspnea than either of them.

Of drugs, digitalis, strychnin, atropin, caffein (or coffee) and alcoholic stimulation are of chief importance. These in proper doses and at suitable intervals will help nature to carry the patient through the danger points. But this paper has already grown to too great length, and their indications are too well known to permit any further elaboration, in spite of the many important points which have not been touched upon. The thing I want to emphasize as strongly as I possibly can, in conclusion, is that nature will cure many cases of pneumonia herself, if she is only given a chance and that the tendency is to interfere too much in this self-limited disease. The nauseating cough syrups we often see poured down the throats of our helpless, but not unresisting, little victims, by irritating the stomach and producing fermentation, not seldom determine a fatal instead of a favorable issue. Let us, then, be watchful to do what is needed, but guard ourselves anxiously against the temptation to do too much in treating the pneumonia of children. "A bitter dose is better than a fine funeral," but a good recovery is better than either.

DISCUSSION.

DR. DUPAQUIER: This is a very good paper. It is one that should be discussed. It is a subject that every practicing physician can discuss. I compliment Dr. Fenner. There seems to be an idea in these days that pneumonia in children is only bronchopneumonia, but lobar pneumonia is also very frequent and common among children. It is one of the correct statements in the paper. The doctor would have relieved me if he had gone a step further and stated that very often lobar pneumonia is not recognized by the best of men. We are asked what the trouble is and we reply that it must be some "gastro-intestinal trouble." A few days later, when the storm is over, we find that it was pneumonia.

In many pneumonia cases it is not a question of secondary pneumonia. We frequently have pneumococcic cases involving the whole organism and a toxemia confronts us. We are treating a case of enteritis, for instance, and may not note that the pneumococcic infection is at the bottom of it all. In children, pneumonia, like typhoid, takes the appearance of septicemia in many instances.

I want to say something here, that no matter what the form of pneumonia is, we always have with us the reliable measures I spoke of yesterday in discussing pneumonia—cold-water, cupping, hypodermoclysis and enteroclysis. In regard to the cold water I do not give it in all cases. I am not going to put in cold water on a weak babe, where these babies cannot take it. I know when to use warm water, too, but I still maintain that these cold applications, when properly carried out in adults and in children, are of great help. Of course, I here repeat that there is no specific against pneumonia and that we should use as little drugs as possible—another good thing that was brought out in this paper.

Dr. Barrier: This subject is of the greatest importance. There are so few of us that do not have cases, especially in children, that I cannot resist the temptation to make a few remarks.

I shall not touch upon the pathology of the disease.

The treatment of pneumonia in children is both negative and positive. I place the greatest stress upon the negative treatment in pneumonia. I think it would be a wise thing for every doctor to have with him, when he is called to see a case of pneumonia in a child, a supply of saline tablets. There has been many a child sent to an untimely grave from overmedication.

As the writer did not bring this out, I will state that a great mistake is made in giving opium in pneumonia in children, especially in the bronchial form. I believe that every physician here will bear me out that the children bear opium less well than adults. Of course, it is a very trying position and a critical time when you are called to see a child that is suffering pain and is breathing with difficulty. The mother says, "O doctor, do something," and we are tempted in such trying crises to give some form of opium. Right there we put the first nail in the coffin of that dear child.

Then there has been many a case of pneumonia that resulted in gastro-enteritis from overmedication and overfeeding. It is just as important to watch that point as any other.

The digestion of the child should be watched even more closely than is the digestion in the adult.

As to the positive treatment I thoroughly agree with the writer of the paper that rest is to be observed. We must get to a point where we can tell the progress of the disease without disturbing the child that is resting quietly. Why disturb it? Give it rest.

I am certainly opposed to poultices of flaxseed or antiphlogistin. If you want to do something merely to have an effect—in other words, to treat the well ones of the household, use a little turpentine. That will do all that your poultices and antiphlogistin could do and will satisfy the well ones.

I agree with him when he says there is no positive treatment. We should treat the symptoms as they arise.

I would not feel that I had done my duty in one of these cases unless I gave my old standby, and that is strychnia. This comes nearer being a specific, in my experience, than anything we can give. We come to the child which is weak, has thready pulse and seemingly cannot last the night, and if we will give strychnia in large doses proportionately the results will be better than with almost any other medicine. It gives splendid results.

DR. LANDAUER: I am surprised that so far we have had no word as to the necessity for fresh air. More children die from suffocation than from any other cause in pneumonia. Go into the bedroom and you will find a lack of fresh air. If the weather is fair they can be left in front of an open window or an open door. Very often, where you have a bounding pulse, cyanosis and strenuous respiration, the pulse will become better and the breathing will be better and cyanosis disappears as soon as fresh air is admitted. Aconite, in the earlier stages, will very often lower the pulse and make the breathing better.

In regard to strychnia, if given with nitroglycerin, it is undoubtedly good. One-fiftieth of a grain of nitroglycerin is a large dose.

Dr. Weis: In regard to the treatment, there are several things that must be considered, and we cannot adopt any one treatment and apply it as a routine in all cases.

In children the pneumococcus variety usually runs a favorable course, and, even if complicated, they usually come through satisfactorily. The streptococcus variety is a very fatal form.

Too much attention should not be given to the sputum examination from a chemical standpoint; the pneumococcus is present in all sputa, healthy and otherwise.

Dr. LeBeuf: In the treatment of pneumonia of small children I believe that the great desideratum is to fix the chest. Whether you use antiphlogistin, bandage, splints or plaster, fix the chest. The idea is to give the thoracic walls a rest. I find that this gives great relief.

I want to say, with reference to the treatment of pneumonia in the country, you are frequently called in to see the patient, and may not see the patient again for four or five days, and the patient very frequently gets well without any treatment whatever. That has taught me that medication is not always necessary.

Dr. J. F. Oechsner: I regret not having heard this paper on a subject of such practical importance. A complication of frequent occurrence is enteritis, to which not sufficient importance is attached. Pneumonia cannot be treated in a routine way and we must always be on the alert for complications. The crisis is much earlier in children than adults. Failure of crisis after a certain length of time should open our eyes to either a further involvement of the affected or other lung or to the development of some complication. A case recently under my care illustrates this beautifully. It was a typical case of acute lobar pneumonia, involving the upper lobe of the right lung. On the twelfth day there was an attempt at crisis, the temperature declining to 100½°. Two days following there was a sudden rise of temperature to 104°, with a corresponding increase in pulse and respiration. Physical examination revealed a consolidation of the lower lobe of the left lung. Three days following the second onset a typical crisis ensued, with a temperature drop to the normal. Two days following this another rise in temperature occurred and the probability of an empyema suggested itself. This was made evident by exploratory aspiration several days subsequently. Pus was found in the left chest. Following rib resection and the evacuation of a large quantity of pus, the temperature again declined to normal, only to be followed two days subsequently by another exacerbation. By this time our little patient was pretty thoroughly exhausted, and I feared further operative interference, but something must be done. Five punctures were made in an exploration of the right chest and about two drachms of pus evacuated. Temperature now rapidly declined to normal and the little fellow eventually made a happy recovery. This case is illustrative of a very frequent complication of pneumonia, empyema, and I should urgently advise that the possibility of its occurrence in those cases in which temperature persists and the disease seems inclined to run a chronic course should be remembered.

DR. FENNER (in closing): There was much that I would like to have brought out in my paper, but the limitations of time prevented me from entering at greater length upon the details of the subject.

What I desire particularly to impress upon you, as a result of my own experience, is that lobar pneumonia is very common, even in very young infants. Another point is that many cases of pneumonia do not require much treatment. Another point is the necessity of watching the digestion of the patient and seeing that the patient is getting fresh air. Ventilation is of great importance.

As to the use of stimulation, I think we are all as one on this point.

In regard to diagnosis I think that there are two things that I have learned in twelve years of practice. They are, first, that there are many cases of pneumonia that I cannot diagnose at all, and, secondly, that there are many cases of pneumonia that must be recognized by inference and not by physical signs. The general condition of the child must lead you, by inference, to make a diagnosis.

The more experience I gain the more thoroughly I learn that there are things that I ought not to do, as well as things that I ought to do, and there are more of the things that I ought not to do than I ought to do, and that, by avoiding these things, my patients are benefited.

In regard to the use of opium in pneumonia I do not know that I ever gave opium to a child in my life. I have no recollection of ever having done so.

In regard to lumbar puncture, I might say that I have had a little experience with it. I wish to assure you that in the case of a child it is so simple that you cannot fail to reach the canal. In the cases in which I have used it I have never seen the slightest damage done. I recall a case this winter, when we suspected meningitis from the various signs indicating that condition. Some of the fluid was withdrawn and found to be sterile. As a result of the small amount of fluid withdrawn the child's symptoms abated and there was rapid improvement. I can only attribute it to the influence of the withdrawal of a small amount of the fluid, which resulted in a relaxation of the blood pressure in the brain. I believe that this ought to be done very much oftener than we do it. It is very simple, hurts the child very little and does the patient no harm, so far as I can see.

Dr. L. L. Cazenavette read a paper on

"Peripheral Neuritis."

Diseases affecting the peripheral nerves of the body are not uncommon; indeed, they form a large and important class of the organic affections of the nervous system.

By the term peripheral neuritis is meant an inflammation of a few or many nerves, more or less limited to their peripheral distribution. The inflammatory action may be of any grade of severity, depending upon the etiological factors and upon the particular structure of the nerve trunk most involved. The inflammation may begin in and may be confined to the fibrous connective tissue of the nerve trunk constituting in reality a perineuritis. The process may limit itself to the interstitial structure of the nerve and give rise to an interstitial neuritis. And then again the axis cylinder may be the principal seat of the inflammatory process, giving rise to what is termed parenchymatous neuritis. In this latter form the pathological process is more of a degenerative character than an acute inflammatory one.

Our present knowledge of the neuronic structure of the nervous system will not allow the supposition that a peripheral nerve can be the seat of a prolonged inflammation without its cell body also undergoing some change. The integrity of the nerve itself being strictly dependent upon the cell body when the latter is diseased or injured, the nerve fiber at once shares in the pathological process.

The true cases of peripheral neuritis include those instances where the nerves are attacked primarily in their trunks or distributions and not secondarily or subsequent to an inflammatory process in their trophic centers.

Clinically, cases are met with where the affection is strictly limited to a nerve and its distributing branches This form is known as the focal or localized form of the disorder. Cases again are met where there is a bilateral symmetrical involvement of a multiplicity of nerves. To this the term polyneuritis or multiple neuritis has been given.

Etiologically the localized form results more frequently from some external influence, such as an exposure to cold, direct injury to the nerve as a result of wounds, compression, truamatism, etc. Also, extension of the inflammatory process from the neighboring parts. The generalized form, a very important one, is dependent mostly upon internal causes, such as toxic substances in the blood.

These toxic substances may be due to poisons within the body, such as those resulting from infectious diseases, such as typhoid fever, diphtheria, variola, tuberculosis, syphilis, influenza and leprosy, and to poisons outside of the body, such as carbonic acid poisoning, carbon disulphide, ether, alcohol, lead, arsenic, mercury, etc.

These toxic states of the system may produce such a condition of the peripheral nerves that slight trauma may cause a severe neuritis. Rheumatism, gout, diabetes, leukemia, are important etiological factors.

Roughly, the above constitute the most frequent causes of the disease. We shall now consider its symptomatology.

A lesion of a nerve necessarily implies a perversion or abolition of the functions of that nerve and gives rise to groups of symptoms anatomically coextensive with the distribution of the particular nerve or nerves involved. These symptoms will also differ according to the intensity of the injury to the nerve. Thus a slight compression upon the nerve may injure the myelin but not the axis cylinder, and the resulting disturbance of function is only temporary.

A most common example of this form of paralysis is that affecting the musculo-spiral nerve, as a result of compression of that nerve from faulty position during sleep, as after a debauch. In these cases we have a unilateral paresis of the common extensors, with involvement of the long supinator. The sensory disturbances are very slight. The paresis may last from a few days to two or three weeks. There is, as a rule, no faradic response of the muscles affected, but galvanic response is qualitatively normal. Complete recovery is the rule. Crutch paralysis is also an example of this form of paralysis.

As alcohol and lead are amongst the most frequent causes of the affections of the peripheral nerves, it shall be my purpose here to recall the most important neuritic symptoms of these disorders.

The symptoms will vary according to the degree of intoxication of the nervous system. Thus we may have in very light cases of alcoholic poisoning no more than a slight disturbance of sensation, consisting of paresthesia, with prickings and numb feelings in the feet and hands. A little weakness in the extremities, not amounting to a paresis, but evidenced by slight tremor. Should the cause be removed, these symptoms pass off and complete restoration follows.

Before proceeding further, let it be said that the symptoms of alcoholic neuritis are symmetrical, and, as a rule, affect both sides of the body in a similar manner. The sensory symtoms are very prominent and because of their severity demand our constant attention during the course of the disease. They are the first to appear and the last to cease. The patient first experiences a creeping, tingling sensation, with soreness, beginning usually in the lower extremities. Motor symptoms make their appearances early and are generally first noticeable in the parts where sensory symptoms first began. There are sharp, shooting pains in the parts affected and there is marked tenderness of the muscles upon pressure. The skin becomes very hyperesthetic. As these cases occur more commonly in women, who are apt to be emotional, the element of pain may, at times, be exaggerated and cause them to scream out. The painful tingling in the soles of the feet, which is increased by standing, causes the patient to walk with a hobbling gait and with great caution, being fearful of increasing the suffering.

Together with these sensory disturbances, loss of muscular power is marked. It may come on gradually, beginning in the lower extremities as a paresis, affecting primarily the extensors of the toes, the peroneal muscles and the dorsal flexors of the foot. In marked cases we have the typical foot drop. In milder cases we may have the gait denominated by Charcot as "steppage." In the upper extremities a similar condition of affairs prevails and the muscles of the forearm and hands are most affected. Besides the drop-wrist palsy, so characteristic of lead paralysis, we may have the claw-hand or ape hand, characteristic of median nerve paralysis. The muscles affected are flabby, soft to the touch and become very sore and painful on pressure. Any attempt at voluntary motion causes excruciating pain and the patients are apt to remain in bed motionless. Other motor disturbances are a coarse trembling, appearing especially on voluntary motion, a clumsiness in the movements due to loss of sensation, and also fibrilary twitchings, especially marked about the small muscles of the hands. The affected limbs lose their normal contour and become cold, edematous and bluish, because of defective circulation. The tendon reflexes are usually lost. The bladder and rectum are never affected.

In the very severe form of the disease the symptoms do not limit themselves to the nerves of the extremities, but invade those of the trunk. The diaphragm and the bulbar nerves may also be involved. These cases generally terminate fatally.

Psychical symptoms form a most distinctive feature of the alcoholic variety, with its hallucinations (visual), loss of memory, especially as regards place and time. In the acute generalized form the lead paralysis marked and severe cerebral symptoms have been noted. Dr. M. H. Thomas reviews the cases of lead palsy seen in the Johns Hopkins Hospital and reports four cases where there were marked mental disturbances. Patients were delirious and difficult to control and other cerebral symptoms were vertigo and attacks of unconsciousness. Even delusions of persecutions, with maniacal excitement, have been seen in one case. The visual disturbances in the lead cases were simply those of sudden blindness, but only of short duration.

The diagnosis of alcoholic multiple neuritis depends on the following: The severe sensory symptoms; the motor symptoms, partaking more of a paresis than paralysis; the peculiar symmetrical localization in the extremities, both lower and upper; the hypersensitiveness of the skin, nerve trunks and muscles; the bilateral distribution of all symptoms; the absence of deep reflexes, and the absence of organic involvement.

Poliomyelitis, a disease of the anterior great horn of the spinal cord, can be differentiated from alcoholic neuritis by the more acute onset of the symptoms in the former, the absence of any objective sensory disturbances and the localized distribution of the paralysis, one of the distinctive features of poliomyelitis.

It may be useful, however, to remember that, as a rule, in chronic metallic poisoning, the arms suffer before the legs, and that in lead poisoning the acute paralysis is limited to the arms; in arsenical poisoning the affection of the arms is soon followed by that of the legs, while in alcoholic cases the legs generally suffer first (Gowers).

The treatment consists in complete abstinence from alcoholic liquors. During the acute stage absolute rest in bed is essential. Care should be taken lest abnormal position of the limbs becomes permanent. The severe pain can be well combated by the use of occasional doses of morphin. It is better, however, to make use of some of the coal-tar products, such as phenacetin and antipyrin. Good results have followed the hypodermic injections of cocain about the painful nerves. Elixir of paraldehyde in teaspoonful doses has relieved the most acute symptoms. After the subsidence of the acute symptoms, the internal use of strychnin, in doses ranging from 1/60 to 1/30, repeated every four hours, should be given regularly and for a long period. Application of warmth to the affected limbs not only help to comfort the patient, but improve the circulation in the part. The use of electricity is also indicated after the acute symptoms have subsided. And here I would like to make a few remarks upon the form of electricity to be used and its mode of administration.

It is but natural and just that in the selection of a drug for internal use we should be guided by the physiological effect of that drug on the system and by the particular effect we wish to produce. The selection of the form of electrical current to be used in any case should be based on the same principle. In the particular case under discussion the aim is to stimulate the paralyzed muscles into contraction, thereby maintaining their nutrition in as good a state as possible during the process of recovery of the nerve; also to stimulate the activity of the anterior gray horn cells which preside over the nutrition of the muscles. The element of pain, we know, can be well combated by the judicious use of electricity.

Of the three forms of electricity in general use, the galvanic, voltaic or constant form of current is the only one which will help us in accomplishing the above purposes. If, however, as in some cases, the faradic current gives us some contraction, it is best to use it; it is by far the best stimulant of muscular tissue.

This current, however, has no penetrating effect. It stimulates the anterior horn cells only indirectly through muscular contraction. But in the majority of these cases the faradic current gives no response and therefore does no good. I should say that its use may be harmful, because its administration on an ordinarily hypersensitive skin causes excruciating pain, and this should be regarded as a contraindication to its use.

Having determined, therefore, that the galvanic current is the proper one to use, its mode of administration should next be considered. A large sponge electrode should be provided and connected with one pole of the battery, usually the negative pole. This electrode is placed on some indifferent part of the body, such as the sternum or chest, or back of the neck. The positive or active pole is then rubbed gently up and down the surface of the paralyzed muscle. By the impingement of this electrode over the different motor points or nerves of the limbs, an interruption in the current is produced and muscular contraction results. The positive electrode should also be used in the labile form over the spine. It should be selected not only because it gives us muscular contraction, but because it is less irritating than the current from the negative pole.

In many cases of this disease seen at the Charity Hospital the improvement could have been attributed to nothing else but the persistent use of galvanic electricity.

Before closing, allow me to call your attention to the following case of peripheral lead paralysis, which, though presenting in itself nothing of great moment, may prove of interest from the peculiar mode of infection:

Observation.—C. Y., white, male, 18 years of age, a resident of Gretna, La., clerk in a hardware store, came to the nervous clinic of the Charity Hospital on October 5, 1904. His complaint was that he was unable to use the hands, right being more affected than the left. Complete double wrist-drop.

Family History.—He knew nothing of his grandparents. Of his immediate family he told us that his father died at the age of 38 from consumption; his mother at the age of 45, cause unknown. Has one brother living, age 26, in good health. Has had seven sisters; two died, one at the age of 20 years, result of an injury; the other when 4 years old, cause unknown. The other five sisters were all living and in good health. He gave no history of rheumatism, cancer, paralysis or any nervous diseases in the family.

Personal History.—Patient has lived in Louisiana most of the time and was the youngest member of the family. Had measles when 8 years of age, has suffered from repeated attacks of malarial fever, but denies having had whooping cough, scarlet fever or any other infectious diseases. He has never had any accidents or any venereal diseases. His personal habits have always been good. He uses coffee and tea very moderately and alcohol and tobacco not at all. His schooling had been very limited. At the age of 14 he began to work in the store where he is at present employed.

History of Illness.—In the beginning of July, 1904, one month before applying to the clinic, he had a light attack of fever. At that time he noticed a lump or swelling on the dorsum of the left wrist. A few days afterwards, possibly three or four, he remarked a similar condition, but in a lesser degree, on the dorsum of the right wrist. Accompanying the above local manifestations he felt a weakness in both hands. By this he meant a partial inability to open the hands, *i. e.,* to extend the fingers. The right hand was more affected than the left. The swellings on the wrists have never occasioned any pain, though they were sensitive to pressure. Two weeks after the hands became affected he had a severe attack of colic, intense pains about the umbilicus, attended with nausea and vomiting. There was also constipation. It was two or three days after this attack of colic that the patient was suddenly seized with complete paralysis of the extensor muscles of the fingers, thumbs and wrists. He does not remember one particular set of extensor groups being more affected than any other. The right hand became thus affected before the left. The power of closing the hand, *i. e.,* flexion of the fingers and thumbs, was not impaired. There was no tremor and no disturbance of sensation. Lower limbs were not affected.

On examination we found that the patient stood 5 feet 4 inches and weighed 103 pounds. He was fairly well developed. There was marked anemia, as denoted by pale mucous membrane, conjunctivæ and lips. The tongue was coated and flabby. There were marked characteristic blue lines along the margin of gums of both upper and lower jaws. Teeth were in fairly good condition. The lymphatic system was normal. Pulse 86, respiration 18, temperature normal. Examination of the thoracic organs showed nothing abnormal. The alimentary system was normal. Skin rather dry and inactive. The cranial nerves were normal. Never had experienced any difficulty of vision. The motor power was examined in the several motor groups in the upper extremities, and the following abnormalities were found: Supination weaker on the right side than on the left; movement left side there was barely a perceptible attempt at motion; the extensors of the index and of the phalanges of thet humb were completely paralyzed. All movements of flexion were normal; the lumbricales and the interossei were not affected. There was no tremor at any time. The extensor groups of muscles on both sides presented marked evidences of atrophy, as also did the muscles of the thenor eminences. The affected extremities were cold to the touch. This was specially marked on the external and outer surfaces of the forearms. The reflexes, both superficial and deep, were normal, except the supinator biceps, which was absent on both sides. The paralyzed muscles did not respond to faradic irritability, but responded to the galvanic current normally, save for a slight quantitative change. There was no reaction of degeneration.

A urine examination disclosed the presence of lead, with traces of albumen.

The intense pallor, the blue lines at the margin of the gums, the double wrist-drop and a history of intestinal involvement presented a picture typical of lead paralysis.

For a time the source of lead contamination in this case was quite puzzling. His occupation, though in a hardware store, where he had nothing to do with the paint department, excluded the possibility of a source in that direction.

Inquiries were made as to his water supply and other sources of infection, but with negative result.

Finally he told us that about November, 1903, ten months before the development of any severe symptoms, he would, boyishlike, place in his mouth some eight or ten small lead shots, known to the trade as No. 10 shot. These he would retain in the mouth from a few minutes to an hour, rolling them about with his tongue between the gums and cheeks. The gritting sound and the peculiar sweet metallic taste induced him to keep up this habit until he was advised to stop it, at the time of his applying for treatment at the hospital.

He says that he never swallowed any of these shots.

Of the numerous sources of lead infection this is certainly an uncommon one. The most frequent cases have occurred in lead workers, typesetters, painters, varnishers, especially those working in carriage factories, where the old paint is scraped off preparatory to putting on a new coat. The most severe and protracted case of lead paralysis I have seen was in a carriage painter.

The use of cosmetics, washing of bottles with lead shots and drinking water from lead pipes are known frequent causes.

The treatment in this case consisted in removing the source of infection; the internal administration of potassium iodide in conjunction with Fld. ext. ergot. (Five grains of former to eight or ten grams of latter.) Occasional doses of the sulphate of magnesia were also given.

The local treatment of the paralyzed limbs consisted in the application of the galvanic form of electricity twice a week to the affected muscles.

A recent examination of the patient's condition shows that he has regained almost complete voluntary movements in all the muscles formerly paralyzed, though these even now do not respond to faradic stimulation. The blue line along the gums has disappeared and he has won in weight twenty-five pounds.

Urine Examination.—Clear, pale-yellow color. Sp. gr. 1,022. No albumen; no sugar; no casts; no traces of lead.

Blood Examination (By Dr. Van Wart)—Red cells, 3,520,000; leucocytes, 5,600; hemoglobin, 65%. Red cells still show slight degeneration.

DISCUSSION.

DR. MENVILLE: I wish to state that in my practice I have had a very similar case to that reported by the doctor in reference to lead poisoning.

I remember many years ago I was called to see a case where there was paralysis of the forearms, with a great deal of pain in the abdomen. The man was a bookkeeper. He had never before suffered any pain. Under proper treatment he made a very good recovery.

DR. GREMILLION: I did not hear all of the doctor's paper and so do not know whether he referred to multiple neuritis or not. Several years ago I had occasion to see a case. At that time I reported the case to the societies. It was a typical case. The reflex was lost, sensation was lost, the respiration was affected and also the heart. The patient went away from my section of the country and settled near Caddo Lake, and one year ago came back to my office. He had improved. But the symptoms had returned. I examined the blood and found the malarial parasite. I was convinced that it was due to malaria, because all the symptoms improved so much under antimalarial treatment.

Dr. Simon: On account of the fact that this disease sometimes follows the antitoxic treatment of diphtheria the suggestion has been made that possibly the antitoxin used in diphtheria has some connection with it.

I have had occasion to see many cases which followed diphtheria in which antitoxin had been administered. The treatment of these cases of peripheral neuritis following diphtheria has been very difficult.

I would like to hear what the doctor's experience has been with these cases of diptheritic peripheral neuritis.

Dr. Archinard: I want to say to Dr. Simon that I believe that the idea of antitoxin having anything to do with the development of this trouble has been disproved altogether and long ago.

I want to insist upon the importance of the diagnosis. The minute symptoms sometimes found in these cases are very important. Yesterday I saw a case that had been in an insane asylum for several weeks.

Dr. Cazenvette (in closing): I have little to add to what has already been said. It is true that malaria is one of the causes of the disease, and, therefore, should be taken into consideration.

Dr. C. M. Menville read a paper on

"A Case of Simple Urethritis Complicated with Satyrio-Erotomania."

This case may invite criticisms from some of the medical profession, who may find fault at the naked exposé of its symptoms and history, but, with due respect to all susceptibilities of such brethren, if any there be present, let me say right here: The sexual organs and their functions are the noblest attributes of man, and their diseases, either psychic or physical, are quite as worthy of intelligent study and considerate treatment as affections of other organs of the human body. False modesty and mawkish sentiment have no place in scientific medicine. At present the ignorance and mock prudery of a large proportion of the profession is absolutely discouraging.

The quicker we shall awaken to a true sense of our worthiness in meeting impotent men, to give them intelligent advice and proper treatment, the quicker we shall raise our standard of usefulness in the army of sufferers and the quicker we shall champion the cause of the poor virgin who is sacrificed on Hymen's altar to satisfy the whims of a medical imbecile who prescribes marriage as a placebo for impotency.

The subject of sexual perversion, although a disagreeable one for discussion, demands the attention of the scientific physician, and is of great importance in its social, medical and legal relations. It is often difficult to draw the line of demarcation between physical and moral perversion. Indeed, the one is so often dependent upon the other that it is doubtful whether it were wise to attempt the distinction in many instances. Hence, the case which I have the honor of presenting involves the diagnosis of psychic and genito-urinary diseases.

A married man of 60, who, in the past, has led a fast, erotic life, came to me with a kyrie of ailments, the most potent of them—being a long sufferer of asthma, with gouty and sciatic pain—simple urethritis, accompanied by a very sensitive urethra, with symptoms of satyriasis and erotomania mixed. The urethritis, being psychic-gleet, presented nothing out of the ordinary, being free from gonococci and having a whitish discharge, which was occasioned partly, if not wholly, by a constant milking of the parts, in order to stop exaggerated masturbating sensations, which he would experience whenever he suspected the presence of his wife, whom he devotedly loved. His general appearance was that of a delicate, nervous, pale-featured man, with distracted look and unsteady gait.

He complained of great pains along the great sciatics and in the inner thighs, but the most distressing symptoms were those of urethral spasms like a vibrating battery, as he would term them, which would produce orgasms with little or no emission. These would occur several times in the night and almost hourly in the day.

He was so impressed with the idea that his wife possessed some occult powers over him to produce these that he felt her presence, even before he heard her coming, by the inordinate movements that would begin in his urethra. These would become very painful and make life miserable to him. He begged and implored her not to come near him, though he professed unbounded love and devotion towards her. These pollutions were bereft of any erections or willing sexual desires. He fought with all the mental energy he could command to resist them. These disorders, he admitted, had been brought about by excessive venery.

Impotency stared him in the face and these constant orgasms were sapping away his life. His mind would wander over his past life, over the idealization of his love for his wife, though he felt convinced that he was a victim of her unconscious powers that brought him so much misery.

Company would divert his mind for a whole day, and, at that time, he would be free from all pain and spasms, to return when left to commune with himself.

By proper suggestions as to the pernicious effects of his milking the simple urethritis soon subsided and his urethra became less sensitive, which I could ascertain by sound introduction.

The psychic phenomena became so alarming that a specialist on nervous diseases was called in consultation and he advised complete isolation from his consort and family, coupled with hydrotherapeutics.

This was done for four months, and, by that time, he felt so relieved of all symptoms that he was permitted to go home.

His condition at present, being a year since he came back, is a complete cessation of all orgasms or genital disturbances, but suffers with persistent pains along the sciatics and different parts of the body, said pains disappearing when his mind is diverted into other channels.

His mind, though far from being well balanced, realizes that the past was due to illusions and hallucinations. He lives happily with his wife, but the prognosis as to his ultimate recovery leaves little or no hope. He eats well and sleeps at times very well, to awaken in the morning with those pains, which are excruciating at times.

Nerve stretching, electricity, hypodermics have been tried with little relief. Constitutional treatment with tonics have also had their say-so, but these pains will persist, and, to my mind, are only psychic in character. His urine is less acid, as he uses a great deal of drinking water and abstains from all alcoholic liquors.

While all the foregoing symptoms pointed strongly to satyriasis, still the erotic furor did not exist except in his hallucinations. On the other hand, could not his excessive venery have had its origin in an unbalanced brain, hence all the sequels that he experienced? This I leave for your able discussion, as in such cases the diagnosis is often difficult, and the symptoms, both psychical and physical, are blended together into a third disease, so as to lose their identity. That disease I shall call satyrio-erotomania.

DISCUSSION.

DR. GELPI: I have listened with a great deal of interest to the description of this interesting case. I think it is almost unique in its kind.

I think that there is no necessity to speak in detail of the symptoms he has brought before us, because every one seems to be so clear and definite.

I agree with what he has said in regard to the treatment of this condition. We find frequently that these poor victims are rather neglected by the practitioners in general and are not taken seriously when they present themselves for treatment. There must be some pathological basis for the condition and that may be a psychic condition or an organic trouble. We must look for that condition and treat that to at least give the patient that hope that he is looking for in desperation.

On the other hand, if we give more time and attention to these conditions we will lessen the field in which the quack is operating with so much advantage and in which we are giving them so much help.

The results would be better to us if we gave these cases more attention and the patients who are now wandering about looking for relief would also be greatly benefited.

DR. P. E. ARCHINARD: It is a compliment to me that this case was brought to me. It was a very interesting case. It was a case of mental and physical wreck, a case evidently brought on by excessive abuse. I had never heard of the like. It was almost incredible. We could not question his veracity. To go into the case would take up too much time and I will simply say that it was a very interesting case from a practical standpoint. It is one of the very unusual cases.

Dr. W. E. Parker read a paper entitled

"Some Notes on the Treatment of Syphilis."

In presenting this paper it is not my hope to present any new plan of treatment for syphilis nor will it be possible in the time allowed to take up the management of certain conditions in which the underlying but remote cause was syphilis. As my experience with this disease has increased I have often thought that our professors (and I don't mean here specially, but in many of our medical colleges) do not dwell at sufficient length on the habits and general surroundings of the patient and that many medical students and young practitioners believe that all that is necessary is to give mercury in some form and the iodide for two years or three years and that the patient is then well. And then many of the patients are young men who do not appreciate the importance of taking the proper care of themselves and who may obey orders for a time, but who begin to neglect themselves within a comparatively short time after primary or secondary symptoms have disappeared. They may take care of themselves for four or five months and then their visits to their doctor become more infrequent and irregular and soon stop. These are the cases that we subsequently see with the late sequelæ.

I believe that syphilis is a curable disease, but it is a steady grind for doctor and patient. As to the general management of these cases, apart from the active medication, I believe that special attention should be paid to elimination. The bowels should be kept regular, the kidneys should be flushed with copious draughts of water and the skin kept open with warm baths. Jonathan Hutchinson is quoted as saying: "I tell my patients that if they will get rid of their alcoholics and tobacco I will get rid of their syphilis." As my experience with this disease has enlarged I have become more and more impressed with the truth of this. The use of tobacco is especially injurious when the mucous membranes are affected. I have seen a number of cases in which mucous patches remained for months under good treatment, and which disappeared rapidly after the tobacco was left off.

As soon as the diagnosis is made the patient should be sent to a dentist and the teeth should be put in order. He will stand his mercury better and will be improved in every way.

As my time is limited I will, as briefly as possible, discuss medication. Generally speaking, it is not wise to begin internal treatment until the secondary symptoms have appeared. If treatment is begun early the secondary symptoms are masked and the patient believes, after a short time, that he has not had the disease and leaves off treatment. Such a case has recently come under my observation. For the care of the chancre frequent washing with a 1/2000 solution of the bichloride or a solution of the permanganate of potassium, followed by the local use of calomel or other antiseptic powder, will, as a rule, get it into a good condition quickly. As the secondaries develop mercury in some form should be used. The protiodide in doses of gr. 1/4, the biniodide or bichloride in doses of gr. 1/10-1/12, or the ungt. hydrargri may be used. I do not use and do not approve of the hypodermic use of mercury. At this time I have charge of two cases in which very extensive sloughs resulted from it. If mercury is to be used by the mouth I much prefer the preparations named. It may be that I have become accustomed to it, but I much prefer the ungt. hydrargri in ʒi doses rubbed into the back daily. To do this properly a rubber glove should be used and it should be rubbed for about twenty minutes. Special care should be taken to see that as to diet nothing should be done to produce salivation. As a rule the effects are prompt and it is necessary to watch the patient to see that no ill effects are produced. Larger and even double doses may be used, but it is necessary to watch the patient carefully, for prolonged use is enough.

These general plans should be followed for six months, when small doses of the iodide of potassium, say grs. x, three times a day, should be added. In the second year the mercury should be continued and the potassium increased to say 20 grs. If the patient has carried out orders well and there have been no manifestations of the disease for two years, the treatment may be carried on for two weeks out of each month for a year, and then omitted.

As to the treatment of tertiary lesions, while mercury should be used, this is the time for iodide and in full doses. If these symptoms are of the nerves, bone or skin, the proper thing to do is to push the iodide to tolerance, and it is better borne if the patient takes full drinks of water. And here let me point out the necessity of watching the condition of the kidneys. In the skin lesions of tertiary syphilis I know of nothing that acts so well as the local use of calomel. I recently had a case in which almost everything had been tried but calomel, that soon got well when it was used locally.

DISCUSSION.

DR. PARHAM: There is one point the doctor brought out that I think deserves serious consideration. That is with reference to the advantage of waiting until the secondary stage presents itself before the treatment is begnu. I believe the time of beginning treatment depends upon the possibility of making a positive diagnosis. Dr. Richardson, with whom I served for a number of years, always made it a practice to wait for the secondary signs to begin treatment, but I am convinced that we should begin the treatment as soon as the diagnosis of syphilis is established. We ought to let the patient lose as little time as possible. If we can make a positive diagnosis with the primary lesion we ought to begin the treatment then. I remember one case in point where I had made a positive diagnosis and there was never any doubt as to the primary lesion. I left the city about that time and left the case in the hands of a friend, advising the treatment at once, but he did not agree with me, and gave him no treatment until my return, about six weeks later, when I found a beautiful manifestation of the secondary stage. I am satisfied the disease would have been more easily subdued had the treatment been instituted when the typical primary lesion was discovered.

DR. GELPI: There was one point that I thought was accepted by all, and that was in regard to the care of the teeth. He might have added something in regard to the experience with the smoking.

Dr. Parker seems to condemn hypodermic injections altogether. It seems that there are cases where we have to deal quickly and rapidly, and, unless we do so, the disease is liable to run a very serious course. In these cases I think hypodermics ought to be resorted to. We have a sure way of measuring the mercury that enters the system and it acts more quickly than in any other method that we have at our disposal. I must say that in only one case the only disagreeable symptom was some pain lasting for some time. In some cases I think we are justified in using hypodermics.

DR. JOACHIM: I cannot condemn the intra-muscular use of the mercurial salicylates. I am an advocate of it. In those cases where urgency is required the result of this form of mercurial treatment is prompt and effective and very gratifying. I do not believe that any who have had responses of that kind would say that there is anything that could have taken its place. In regard to Dr. Parham's remarks to the effect that treatment should be commenced as soon as the diagnosis is made, I will say that two cases came under my observation during the last few months where the specific infection was denied in both and declared as not syphilitic by the very excellent men who examined the original lesion. In both the mucous patches presented themselves, but I hesitated to pronounce them as such. Both cases had mucous patches in the throat and one had them on the vocal cords. The local treatment had in a way marred their characteristic appearance, but when the mucous patches broke out on the vocal cords there was no longer a question about the correctness of the diagnosis, which subsequent treatment confirmed. This raises the question whether it is always possible to make a positive diagnosis in original lesion.

DR. BRUNS: This is a subject that we can all discuss with advantage. We all treat syphilis. I have tried the hypodermatic injection and believe that it is the worst way of giving mercury. It is painful and sometimes salivates when you least expect it. Once, almost in the twinkling of an eye, I witnessed the most fearful mercurial poisoning that I have ever seen. An inunction of a drachm should be given at least once a day. If one drachm is not enough, most men will stand two.

There is one thing that is often forgotten and that is the addition of belladonna to the mercurial salve. A drachm of extract of belladonna should be added to an ounce of the mercurial ointment. The proof of a pudding is in the eating. I have not had a case of mercurial sore mouth in many years. Another good thing about the inunction is that patients cannot pretend to be taking medicine regularly when they are really neglecting it. When the eyes are affected we have a good excuse to rub it into the forehead, because the belladonna relieves and we can see plainly that the patient is receiving his daily dose. I refer specially to hospital patients. Iodides should not be given by the dose, but to the point of tolerance. You must keep increasing the dose until your patient cannot take any more. It goes without saying that during the time you are giving the iodides you should encourage your patient by every means to drink water, and to drink it freely. A useful adjunct is the Turkish bath. If they are not to be had the patient should take a hot drink and have a hot bath, go to bed and roll himself in blankets until a profuse sweat is produced. Such a treatment, vigorously carried out, answers all the purposes of a trip to Hot Springs.

Dr. Parker (in closing): As to what Dr. Parham has to say about the treatment as soon as the diagnosis is made, I think that the diagnosis can be made very quickly and without difficulty. If you start to treat them, they will go on for four or five months, and they will then get the idea that the doctor may be mistaken. It is with the idea of impressing them with the fact of the disease. I recently had a case come to me. He had a sore, and saw Dr. Taylor, and they gave a diagnosis of chancre and put him on treatment. He took his treatment for three or four months and then he stopped. When he came down to see me it was with the idea of impressing the patient that I made that point. He must be brought to realize the necessity of taking care of himself.

I was very glad to hear the ideas brought out by those who discussed the paper.

ADDENDUM.

(Cut opposite is to accompany paper by Dr. J. T. Halsey in January number. Radiograph received after January Journal was printed.)

At top of picture is what is interpreted as the lower limit of a cavity containing bismuth paste. Below this is a U-shaped shadow—that of bismuth which has found its way into stomach. Extending horizontally across the picture at the bottom is the shadow of transverse colon, rendered visible by bismuth given three days before picture was taken.

ew Orleans Medical and Surgical Journal.
February, 1906.

SHADOW OF DIVERTICULUM.

CASE OF DR. HALSEY.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Ten Years of Service.

With this number of The Journal the present editors terminate ten years of service in the management of the publication. They are gratified in the realization that their one hundred and twentieth number is in most respects a good deal better than their first; also, that each and every number has appeared punctually on the first day of the month, except when same has been a holiday; again, that the number of its subscribers and advertisers has materially increased; further, that its stockholders have not become impoverished; but, above all, that in the meantime the medical profession of Louisiana has reached a higher plane, with better organization, and that perhaps The Journal has had a modest share in the work of bringing this about.

Whatever time, labor and thought the editors may have given to their undertaking, they feel that they would have accomplished little had it not been for those who could and did help. Their gratitude must go out to their collaborators, their business manager, their readers and even their printers, though the latter have oft made them sweat blood. They must also express their appreciation of the important scientific work done by the Louisiana State Medical Society and the Orleans Parish Medical Society, whose contributions to these pages have materially increased the size and value of each volume.

Through their connection with The Journal the editors have gained much in knowledge and experience, if less in wealth; they are thankful for it all and propose to do all in their power to give satisfaction to their patrons and friends and cause confusion to their enemies—that is, such as cannot be won over.

State Board of Health.

We are pleased to note that the editorial on health matters in our last issue has received the approval generally of the medical profession. In one or two instances, however, we have been asked why we "condemned" the new State Board of Health in advance; hence we must make our position very clear on the subject.

We did not condemn in advance and do not now condemn the State Board. What we have already said we said purposely in advance in order that there could be no application of our opinion in a personal manner. We did not then know who would constitute the board; hence our objection at that time was not and is not now aimed at its personnel. We did object and still disapprove of the method of the appointment and organization of the new board and for the reason that it savors too much of politics, in the small sense. We could give numerous specifications, but one or two will suffice. For instance, we knew about one month previous to the first meeting of the new board and before its membership had been definitely settled, that Dr. Patton would be dropped and that a layman, a newspaper man from Shreveport, would get his place as secretary to the board. Again, we knew that employees of the board, medical or clerical, incumbent or aspirant, were less concerned about the members of the board than they were about their influence with the Governor of the State or his political friends. To be brief and blunt at the same time, we felt that the occurrences of last summer had taught no lesson to the political powers; that it was the same old game. The medical profession was very useful as long as there was trouble, but they received precious little consideration when the trouble was over.

Nevertheless, and we desire not to be misunderstood on this important point, the board as at present constituted is the legal authority in the health matters of the State, and, no matter what we may think of its creation and organization, we propose to do all in our power to assist it every time and in every way should the opportunity arise.

Incubation of Yellow Fever.

The report of Dr. John N. Thomas, physician in charge of the Louisiana Mississippi River quarantine, concerning the outbreak of yellow fever last year, is most interesting, yet too lengthy to admit of publication in our columns. It is available to all as it has appeared in the newspapers. It makes a strong presentation of the contention that the fever was introduced into New Orleans from Havana, and, while no proof can be adduced, it shows how it might have been, even if it was not.

Its greatest importance, in our opinion, lies in the fact that it shows that in over 10 per cent. of the cases of yellow fever in which it is known that the period of incubation has been absolutely determined that period has been more than five days. The lesson is obvious when applied to quarantine rules, detention periods and other sanitary measures, which should all be made to conform with the fact.

A Precedent Established.

The frequent practice of the daily press to make news of medical achievement sometimes leads to error. Often it is the case that the garbled account of some surgical procedure incident to some accident in the public street sensationalizes an occurrence of small moment. At times some prominent citizen meets with the necessity for professional skill and the physician or surgeon becomes a part of the general news which in a way belongs to the public. During the suspense attendant upon the last hours of the German Emperor, the fatal ending of the lives of Presidents Garfield and McKinley, medical bulletins with exact information were delivered at regular intervals to an expectant public.

Medical discovery is heralded always, and if sensationalized this is explained upon the idea that the news is therefore more readable or attractive. With such there may be some license accorded, but even in these instances the usual press representative is too little educated to present a technical subject in a secular way.

The search of news, the element of the sensational, the mysterious in all things medical morbidly attract the average news purveyor and as a consequence they go out of the way to procure such bits of information.

In New Orleans the frequent occurrence of newspaper accounts of Charity Hospital and private practice experiences in the medical and surgical fields occasioned a consensus of opinion, deprecating such, and a set of resolutions resulted from the Orleans Parish Medical Society, the representative medical body of New Orleans. The press was urged to aid the Society in eliminating such reports from their columns, as they tended to do no good and were actually looked upon as derogatory to the morale of the profession, looking at the question from the point of ethics.

The first opportunity afforded thereafter, one of New Orleans' prominent practitioners was flagrantly exploited by a local paper as having achieved some great cure under a series of circumstances which did not exist in fact, but only in the zealous interpretation of a fond father's statement percolating through the cranial sieve of a newspaper reporter—all without the knowledge or consent of the attending physician. The review was kindly meant, but did actually misstate facts, impinged the doctor in question upon the pale of criticism at the hands of his fellow craftsmen and exposed him to censure by his affiliates in the afore-mentioned Society. With the twofold desire of checking further abuse of himself or others, through the newspaper medium, and of exonerating himself in the particular instance, suit was brought for damages to his character, feelings, etc., and an adverse decision was rendered in the District Court on the ground that the case was not actionable. Later, the Supreme Court of Louisiana (Justice Breaux) decided the lower court in error, reversed the decision and made the case actionable and the defendant charged with costs.

THE JOURNAL is not ready nor willing to argue the case, but considers a natural deduction apropos.

The invasion of the private affairs of any citizen must be open to censure, and in the practice of a physician this is especially true and applicable.

On the other hand the newspaper itself should be careful to discriminate between news and sensational reports. Every public man is the property of the news gatherer, and in his public relation he should be prepared to be used by the newspaper as news, even if he be a doctor, but even if he be a public man, his private practice should and must be respected.

A precedent has been established, and one with a valuable lesson attached. Both patient and physician should be slow to spread information, true or not, lest it become news. We understand, notwithstanding the suit, that no malice existed, and that both parties to the suit are friendly—as yet. Meantime, the newspaper awaits the trial of the suit, and the profession locally is interested in the result and its effects.

American Association for the Advancement of Science.

Although the New Orleans meeting was small, it was none the less representative, and the several days of sessions represented made earnest work. It was not until the actual proceedings were under way that the people of New Orleans began to realize the importance of the gathering. Among the many conventions which have found their way or have been led to New Orleans, this, perhaps, was the most important. Not only abstract science found discussion, but there were symposiums on domestic, sanitary and social life. Psychology and astronomy, as well as mathematics and public health, were touched upon.

Long after this meeting its influence will be felt in the community.

Along the Line.

While the questions of theory in diseases and their application to practical hygiene are under consideration, we should think some of the wider purpose of public health in its relation to food products and the protection of the public against itself. *Collier's Weekly* is doing noble work in arming the public with the knowledge of dangerous patent medicines, but this alone will not effect the result to be desired. Earnest, active effort in creating and in promulgating and in enforcing drastic legislation must be accomplished. Too many parasites are feeding on the gullible public for them to quietly yield their position. Already there has been some organization against the "Pure Food" bill, and even if this goes through the standard (God save the mark!) patent medicines will try some other way. No matter how potent be the desire to rid the world of the menaces to a sound body, the element of money is always paramount, and until the daily newspaper and the unscrupulous periodical are made to fall in line, the way will be hard. With the debate in Congress, published in one column, the opposite page of the daily press is just as apt to carry a full page advertisement with flagrant testimonials to the very remedies discussed, both as news and in editorial persiflage!

Argument will not avail, for that has already been employed, and with the exception of such papers as the *New York Evening Post,* no stand has been taken against the evil by any of the news purveyors.

The pendulum swings two ways, however, and as it comes back there may be some conscience driven through the hide-bound commercial instinct of the daily press to gain their support; but this must be done *vi et armis,* through a united effort for legislative direction and control administered under rules of misdemeanor.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of Dr. F. W. Parham, Assisted by Dr. F. Larue, New Orleans.

INHIBITORY AND ANESTHETIC PROPERTIES OF MAGNESIUM SALTS.—In the *Medical Record,* December 16, 1905, Dr. S. J. Meltzer gives a report of the results of the remarkable experiments of himself and Dr. Auer on the inhibitory and anesthetic properties of magnesium salts. This work is the result of his investigations in inhibition. A number of valuable articles on this subject have appeared in the past, but the practical results of this work were first presented at the Academy of Medicine December 7, 1905. These experiments go to show that magnesium sulphate has some remarkable anesthetic properties, but the most striking results were discovered when the solution was introduced into the spinal canal. Clinical tests were conducted with twelve cases, after elaborate animal experiments which justified the employment of the method in men. He says: "To sum up the experience as far as I could gather from these twelve cases: One c. c. of a 25 per cent. solution of sterile magnesium sulphate to 25 pounds body weight causes, in three to four hours after intraspinal injection, paralysis of the legs and the region of the pelvis, and analgesia, which is sufficient to permit the performance of any operation upon these regions. Sensation and motion return within 8 to 14 hours; retention of urine and the necessity for catheterization may be present for one or two days. There is, however, one case in which only a moderate dose of magnesium sulphate was used, but the after-effects were very prolonged. Retention of urine lasted for about twelve days, and the paresis improved only very slowly; for days there were also irradiating pains into the legs. It is too premature to discuss the causes for the protracted after-effects in this particular case. I am inclined to believe that it was due to some of the incidents of lumbar puncture, and was not specifically an effect of the magnesium sulphate. I feel confident, however, that an irrigation of the intraspinal cavity soon after operation will shorten or do away with all after-effects.

"A dose of one c. c. to 20 or 18 pounds body weight would permit, a few hours after the injection, the performance of extensive operation on the abdominal cavity and probably even higher up without the aid of any general anesthetic. However, from what I have seen I am of the opinion that it is preferable not to wait so long, but rather to operate about two hours after the injection with the aid of a very small quantity of chloroform. But in this case I would urge that a lumbar puncture be made again immediately after the operation, and a quantity of spinal fluid be let out at least as large as that of the injected solution of magnesium sulphate, and then that the canal be irrigated several times with sterile salt solution, finally leaving some of this fluid in the canal."

In the discussion which followed the reading of this paper, Dr. Joseph A. Blake, Dr. Willy Meyer, who had operated on cases under this form of anesthesia, spoke of the method in commendatory terms.

Dr. Meltzer further remarked: "Finally, I feel a special delight in being able to report that at the Roosevelt Hospital a desperate case of tetanus was cured. After the employment of 115 c. c. of antitoxin without any avail the first injection of a solution of magnesium sulphate afforded great relief for 36 hours, and after a few more injections the patient seemed to be cured. Dr. Blake, in whose service this happy incident occurred, will tell you the particulars."

This last seems to be a very valuable suggestion. We learn that it has recently been applied in a case at the Charity Hospital in the service of Dr. Matas. Although the patient died, the complete muscular relaxation following the intraspinal injection was most remarkable. It would seem that the effect of this method in producing such complete relief of the tetanic spasm ought, if not actually curative itself, to be of the most valuable assistance to other forms of treatment in this most dreadful surgical malady, which, has so far, in our hospital practice, given a mortality of from 60 to 90 per cent. It is, of course, yet too soon to say what degree of advantage it will possess in the treatment of tetanus, but Dr. Blake's case, as related by Dr. Blake in the discussion of Meltzer's paper, certainly makes it worth our most serious consideration.

RANSOHOFF'S SIGN OF RUPTURED GALL-BLADDER.—Ransohoff, in his paper at the recent meeting of the Southern Surgical and Gynecological Association, mentioned jaundice at the umbilicus as a sign he had observed in a case, and he hoped further experience might show it to be a valuable indication of free bile in the peritoneal cavity. The umbilicus being thin, allows it to soak through and become evident on the abdominal surface at that point.

RADIUM-TREATED CASES.—That was certainly an impressive presentation of radium-treated patients made by Dr. Abbe before a recent meeting of the Practitioners' Society of New York. The first patient was a man of 45 years, who had suffered for five years from a group of hot, burning and itching, red, lupus-like masses in the center of each cheek, about one inch in diameter, very distressing in character; five applications of strong radium in glass tubes, one-half or one hour at a time, at one week's interval, resulted in radical and permanent cure.

The second case was a case of epithelioma of the ear, cured by a few applications, the cure now lasting one year and a half.

The third patient was of the same kind, existing for eleven years, in spite of operation and skin grafting, caustics and curette, gradually destroying nearly the upper half of the ear; two strong specimens of Curie radium, laid upon the sore five times during a single week, brought about great improvement in appearance in five days, and almost complete cure in one month.

The fourth case was one of slow growing epithelioma below left nostril, which, during seven years destroyed the ala nasi and part of the columna, and even the lower lip down to the vermilion border. The entire surface was deeply ulcerated and had thick, raised edges. The patient was a woman of seventy-five. Several strong radium tubes, laid for one hour seven times in ten days resulted in healing of the disease in five weeks.

The fifth patient was a remarkable case of sarcoma of the lower eye-lid cured by four rayings of one hour each during one week.

The sixth case was a rapidly growing giant-celled sarcoma of the lower jaw in a lady, cured by fifteen severe treatments and remaining cured after two years.

The seventh patient illustrated the infallible effect produced by radium on warts of the ordinary type.

The eighth patient showed a rare form of glandular disease of the upper lip, much benefited within a fortnight.

Department of Obstetrics and Gynecology.

In Charge of Dr. P. Michinard and Dr. C. J. Miller, of New Orleans.

Dilation and Curettement for Dysmenorrhea.—G. R. Holden (*American Medicine,* Nov. 4) analyzes the reports received from 95 patients at periods varying from one to twelve years after dilation and currettment for dysmenorrhea. He finds that 40% were entirely or very greatly relieved for at least one year, with 7% out of this 40% having a recurrence of the dysmenorrhea after one year or more; 30% had no relief at all, while the remaining 30% had but slight relief or relief for a few months only.

Marked maldevelopment of the pelvic organs was present in 20 cases, and in only 25% of these were the patients relieved. From a study of the character of the pains, Holden concludes that the prognosis for relief after dilation and curettement is better when the pains are sharp, begin the day of the flow or the day before, and last but a day or two. The prognosis is had when pains are dull, begin several days before the flow, and last for several days, or throughout the flow.

Dysmenorrhea may be caused by lurking pelvic inflammatory disease which is not recognized at pelvic examination under ether. In these cases dilation and curettement may make the symptoms much worse. Neurasthenia, anemia or malnutrition are frequently present. In some cases such are the cause of dysmenorrhea. To get good results from the operation these conditions must be cured. In 61 of the cases a microscopic examination of the curettings was made. Chronic endometritis in such relation as to be a possible cause of the dysmenorrhea was present in but 4 cases, hence Holden concludes that chronic endometritis is an infrequent cause of dysmenorrhea.

As but 3 out of 20 sterile married women of this series in the child-bearing period conceived within a year after the operation, the value of dilation and curettement in relieving sterility does not seem great.

In general the procedure should be limited to cases in which there are no gross pathologic lesions, such as retrodisplacements, inflammatory disease of the adnexa, or myomas, to account for the dysmenorrhea.

RETROFLEXION OF THE UTERUS.—Vedeler, B. C. (*Novdisk Medicenskt Arkiv.* 1904), states that he has examined the position of the uterus in 7,238 women, of whom 834 were virgins, 2,037 nulliparæ, 913 gravidæ and 3,146 paræ.

Anteflexion was present in 64 per cent., retroversion in 20 per cent., retroflexion in 9 per cent., and anteversion in 7 per cent.

Vedeler states that if patients can be kept under observation for a long period retroflexion may be observed to be spontaneously transformed into anteflexion, and vice versa, and that retroflexion may long persist without producing any diseased condition in the uterus.

In parous women the proportion of healthy to diseased uteri in ovarious positions was, in anteversion, 52 per cent, anteflexion 58 per cent., retroversion 57 per cent., retroflexion 55 per cent.

This table shows that anteflexion, usually considered to be the normal position, possesses the greatest morbidity, whilst retroflexion occupies the third place.

Vedeler objects to fixation of the uterus and pessary treatment, and considers that the diseased retroflexed uterus should be treated on the same principles as the diseased anteflexed uterus, and that in the absence of all symptoms it is unnatural whether the uterus occupies a faulty, or a correct position.—*Jour Obst. and Gyn., British Empire.*

Department of General Medicine.

In Charge of Dr. E. M. Dupaquier, New Orleans.

Diet in Enteroptosis.—Great care should be taken as to diet. Starches and milk, both of which are prone to produce flatulence, should be avoided. If starch is used in an easily digested form, as rice and cornstarch, some taka-diastase should be given with it. Cheese and beans are absolutely forbidden, and fats are also harmful. Small quantities of green vegetables may be taken, and roast or broiled beef and mutton allowed at each meal. Eggs are also permissible. The patient should be warned against eating heavily at any one time, since overweighed stomach or colon will make the ptosis much worse. If gastric dilatation exists, lavage may be useful.—[Hare's Practice of Medicine, 1905.]

* * *

A Substitute for the Plain Water Diet.—It is seldom possible to continue the plain water diet over 24 hours for babies sick with gastro-enteritis. The advantage of stopping milk feedings for a longer period is obvious, and by means of the present substitute it can be attained. The recipe is from Mery's special service in Paris, and the results are positively good. It is a simple thing, but requires attention. Take of

Irish potatoes	60 grammes.
Carrots	45 grammes.
Turnips	15 grammes.
Dry peas or beans	6 grammes.

Place all this in one litre of cold water and boil during four hours in an earthen or porcelain pot which is carefully covered. Strain, add enough plain boiled water to make one litre in all, and 5 grammes of table salt. Prepare fresh every day, and in summer twice a day. Keep in a cool place, preferably in a refrigerator. This "decoction," so to say, is given plain in the feeding bottle. It is pleasant and the babies like it. For a change rice farina can be prepared with it, the result being a liquid pap also given in the feeding bottle. This is how to proceed. Mix the farina with the decoction when cold, mix thoroughly, then heat some more decoction and add it when warm to the mixture. Cook the whole during 15 minutes.

The quantity of farina varies, as follows: Under 6 months, half a teaspoonful, over 6 months, one teaspoonful to each 100 grammes of decoction.

The quality of liquid pap thus obtained varies from 50 to 150 grammes every 2 hours, according to age and condition.

The diet of plain water, substituted by the decoction, with or without farina, is alternated and continued until the stools are yellow, more consistent and less frequent. Then only should the milk diet be resumed, first using the milk diluted with the decoction mixed in various proportions, then alternating this with a feeding of milk diluted with plain boiled water. Then for a change resuming the plain water diet and plain rice farina liquid.—*Journal de Medicine et de Chirurgie Pratiques.* Dec. 10, '05.

CAUSES OF LOW TENSION.—(a). Low tension may be a constitutional peculiarity in some individuals and families, when it may be associated with increased frequency in some cases or obesity and weak cardiac action in others (diminution in capillary resistance). (b). Temporary low tension is caused by warmth, as weather, baths, hot drinks and food. (c). It may be dependent upon nervous causes, as mental or nervous exhaustion from whatever cause. (d). Debility due to malnutrition or secondary to chronic disease. (e). Pyrexia generally causes a full, bounding pulse, usually in proportion to its degree. Later the pulse may become weak, quick and dicrotic, on account of the effect of the high temperature on the cardiac muscle or the influence of the toxins on the heart itself, or on the nervous system. (f). Cardiac diseases. As the pressure in arterial system depends upon the amount of blood that is forced into it, as well as the resistance to the passage of the blood through the arterials and capillaries, the tension will be lowered whenever the heart is unable to empty itself on account of valvular disease or of muscular weakness. In aortic insufficiency the collapsing or water-hammer pulse is due to the sudden fall in the blood pressure caused by the free regurgitation of blood into the ventricle.

Causes of High Tension.—(a). Temporary high-tension pulse may be caused by increase in the amount of blood, as occurs for a short time after meals or after taking large quantities of water, and is persistent when the elimination of the fluid by the skin and kidneys is interfered with, producing permanent overdistension of the blood vessels. (b). It may be also temporarily increased by frequent and powerful overaction of the heart, as occurs in mental or emotional excitement and in the early stage of physical exertion. Or (c) it may be due to temporary increased resistance in the blood vessels, as occurs from external cold, congestive chill or hysteria. (d). Drugs, ergot and the digitalis group. Permanent high tension may be caused by all those factors which cause increased resistance in the capillaries, as (a) chronic toxemia, as occurs in gout, rheumatism, lead poisoning and in renal disease; (b) changes in the walls of the capillaries which interfere with permeability, as atheroma and arterio-capillary fibrosis. These changes may be primary or secondary.—[Physical Diagnosis, Egbert LeFevre, M. D., 1905.]

Department of Therapeutics and Pharmacology.

In Charge of Dr. J. A. Storck and Dr. J. T. Halsey, New Orleans.

Treatment of Uncinariasis.—Phillips, of Cairo (*Journal of Tropical Medicine,* December 1, '05, p. 341), calls attention to the fact that not infrequently treatment with thymol is either unsuccessful, takes an unduly long time, or is attended by the appearance of undesirable symptoms due to the toxicity of this drug. He has tried in a series of over 100 cases eucalyptus oil as a vermifuge, making use of one or the other of the following mixtures:

R. X.	Olei Eucalypti	gm	2.0-2.50
	Chloroformi	gm	3.0-3.50
	Olei Ricini	gm	40.0-40.0

The patient receives at 6 p. m. a saline purge; fasts during the night, and at 7 a. m. and 7:30 a. m. receives half of above mixture. He is kept in bed until bowels have moved. With children or weak patients the weaker mixture is used and may be given in three doses at 20 minutes intervals. With adults in fairly good condition the stronger mixture is used. This treatment can be repeated each second day until negative results indicate either complete failure or success of treatment.

In a series of over 100 cases there were four complete failures. In a number of cases the patients left the hospital before it could be said positively that the treatment had succeeded in removing all of the hook-worms. Phillips at no time or in no case observes any alarming symptoms due to the absorption of the drugs given. He claims for the treatment as its chief advantage, efficacy equal to or superior to the treatment with thymol; that it is cheap; that it can be repeated frequently and that in his experience it has had no bad effects.

In view of the frequency of cases of hook-worms in this section of the country, and of the fact that it is well known that thymol from time to time has produced serious results, it seems worth while to call attention to this method of treatment as an alternative of the more usually employed one.

NOVOKAIN: *A New Local Anesthetic*—Danielson (*Munch. Med. Woch,* V. 52, p. 2218), as a result of his experience with novokain in sixty surgical cases, expresses the opinion that "Novokain is an unirritating, prompt and powerful local anesthetic, which has no toxic, irritating, painful or necrosing side actions or effects. It does not interfere with the action of suprarenal extract and can be readily sterilized." He is convinced that "Novokain is the only drug at present available which can replace cocaine." He strongly recommends it for use in surgical practice.

Schmidt (*Ibid.,* p. 2220) has used novokain in seventy cases with considerable satisfactory results. "The especial advantages are to be found in the extremely slight toxicity, combined with great anesthetic power of the drug and the absence of all irritating or pain-producing side action."

The drug is also praised highly by Braun, the great advocate of local anesthesia; Haenel and Biberfeld. It is said to be only 1/7 so poisonous as cocaine. For infiltration anesthesia 1% solutions; for ordinary local anesthesia 1% to 2% solutions are used. Solutions can be sterilized by heat and may be kept in dark bottles for a considerable time. As much as 0.25 grammes have been injected with no bad effects; usually about 0.06 has been used. In 10% solution it may be used as application to mucous membrane and is especially recommended for use in dental work. It is frequently combined with adrenal or other suprarenal preparations.

CLAVIN, A NEW DERIVATIVE OF ERGOT. Vahlen has succeeded in obtaining from ergot a chemically distinct crystalline body, to which is given the empirical formula $C_{11}H_{22}N_2O_4$. It crystallizes out of hot alcoholic solution in prisms 7 to 8 mm. long. These sublime on careful heating and they are soluble in dilute alcohol and in water, but insoluble in cold absolute alcohol, ether and benzine. When given internally it does not produce cramping pains or gangrene, like ergot, and is free from other general effects. Animals can bear intravenous injections of several decigrammes without toxic symptoms. Its specific effect on the uterus is apparent after doses of some centigrammes. It has been tried in the Frauenklinik, at Halle, and in the "Charite," at Berlin, and proved effective in dilatory pains. Given by the mouth, or subcutaneously, tablets 2 cg. being used; for injection, the tablets contain 2 cg. of clavin and 8 cg. of Na. Cl., one being dissolved in 1 c.c. of water. The aqueous solution can be sterilized and solutions should always be freshly prepared, as they get cloudy on standing and develop an unpleasant taste.—*Therap. Monat.—The Practitioner.*

TREATMENT OF OBSTINATE NEURALGIA BY OSMIC ACID.—Dr. Wayne Babcock, professor of surgery, Temple College, Philadelphia, advocates the employment of osmic acid in the treatment of neuralgia. He reports a case of tic douloureux of long standing in which various resections of nerves had been performed without benefit. He exposed the inferior dental nerve and injected Mxii of a 2 per cent. solution of osmic acid into the trunk. After the first night the relief was complete and permanent. He considers that this method should be properly tried before resorting to removal of the Gasserian ganglion. Treatment of neuralgia (sciatica) by osmic acid was first introduced about five and twenty years ago. Weak solutions were injected as close to the nerve as possible. The results were untrustworthy and the treatment was given up. It was again tried, about eight years since, by W. H. Bennett, who exposed the nerve and injected Mx-xv of 1 per cent. solution directly into the trunk. His results were uniformly favorable (*Therap. Gazette,* Aug., 1905.). Other cases of sciatica are known in which osmic acid was injected into the nerve trunk and complete relief was obtained. One case, a working man, was completely incapacitated by sciatica. One injection into the nerve was given ten years ago and he has been able to earn his living properly ever since.—*The Practitioner.*

SANTONIN IN PHTHISIS.—This is used in Tashkend by the natives for the cure of the disease and apparently with success. Carl Tollens has made a series of researches in Göttingen on its pharmacological properties and finds that it lowers the temperature and influences the respirations by decreasing their rate and increasing their volume; phagocytosis is also increased.—*Munch. Med Woch.*

FOR HYPERCHLORHYDRIA.—Von Bergmann uses tablets containing pilocarpine and alkalies.

Albu, of Berlin, recommends:

℞	Ext. Belladonnæ	gr. v.
	Bismuth Subnit	
	Magnesia	
	Sodæ Bicarbonat	Each ʒiiss

Ft. pulv:

"Half a teaspoonful to be taken one to two hours after the chief meals of the day."—*The Practitioner.*

Oxygen in Chlorosis.—Lefèvre (Thése de Lyon) reports a number of cases which indicate that if iron is not well tolerated in severe forms of gastric disturbances in chlorosis a preliminary treatment by inhalation of oxygen may be of value. The gas was administered by the Kraft method, closing one nostril, inhaling through the other and exhaling through the mouth. This treatment continued for a month and resulted in increase of appetite, reappearance of menstruation, disappearance of cardiac murmurs, etc.—*N. Y. Med. Jour. and Phila. Med. Journal.*

Miscellaneous.

Parisian Medical Gossip.

(Translated by DR. T. C. MINOR, Cincinnati, Ohio)

Mustard in Capillary Bronchitis.—Heubner and Herzfeld both recommend the use of mustard as an evulsive in the treatment of capillary bronchitis to combat the symptoms of asphyxia. *La Reine Médicale de Louvain* shows their technics, for they vary. According to Heubner, a pint and one-half of hot water is used; to this is added 500 grammes of fresh mustard—sometimes more. Boil until the essence makes the eyes and nose of the operator water. This takes about ten minutes. A piece of flannel is dipped in this mixture and the child's chest completely covered. The application should be used for ten or fifteen minutes until the infant's skin is red. A tepid bath is then given the child, so that all small particles of mustard are removed, and it is then wrapped up in flannel wrung out in very warm water, this application being kept on until profuse sweating is induced, say a half-hour or an hour. If the child's face grows very red remove sooner. Another warm bath is now given and then a tepid sponge bath, then a cool water lotion is applied. The patient is then dried off, wrapped up warmly and allowed to remain without other treatment the remainder of the day. The results of this revulsion we noticed the following day. The fine rales dimish, respiration is freer and a betterment is observed. The operation is to be repeated for several following days, but only one application in twenty-four hours. Herzfeld's procedure is somewhat similar. He mixes 250 grammes of water, 250 grammes of alcohol and 15.50 centigrammes of essence of mustard. The chest of the child is covered with a flannel saturated in this mixture and the application allowed to remain until the skin reddens and the circulation improved. The revulsion should last half an hour or less. Equal parts of water and alcohol are then used on a piece of flannel placed around the child's chest, kept there for about half an hour. The infant's skin is then dried off and it is warmly covered. This application may be made several times a day at first. This variety of simple mustard baths permit us to avoid the emanations of mustard that so often irritate a child's mucous membranes.

FEUILLETON OF LUTAUD.—Lutaud, editor of the *Journal de Medicine de Paris*, in a recent feuilleton, remarks:

"When will we resume our good medical sense?" said a high medical personality to me only the other day. Let us hope it will be very soon, for medicine has grown very weary of serums and so-called preventive vaccinations against cancer (Is this not true, Prof. Doyen?) of apotherapy. We now put, it is true, the ancient medicine that is true, the medicine founded on experience and observation, above that of the Chemist Pasteur, from whose time it appears

"Under the purple floating
Under a brazen sky."

As the philosopher, Auguste Compte, says, "Moderns cannot destroy that which they merely replace."

What is the result? For hydrophobia, croup, etc., etc., we take no account of favorable cases and we wipe out, with a sponge, the numerous cases that do not answer to fit the illusions they seek to make. The idea was simple: disease only lurked at the bottom of fermentations; seek the microbe, kill it; that was all.

Here was an army of doctors armed with microscopes, with vases, alembics, test tubes, culture bottles, etc. (grand moral effect on the patient if he survived). They cultivated bacillary broths; as to the malady, that was quite another affair.

This simple idea loaded its inventor down with decorations, the nation was glorified (*medically*), statues were erected and still remain.

This was sad. Yet some of us, and many profane and ancient country doctors hold their noses with disgust at the odor of such public incense. This is what our good friend Labiche does, and observes: "It makes one blow his nose in four parts." But, what did they do with the patient? Old-time doctors knew full well (from the days of Hippocrates) that disease is not one—that it behaves in different manners following the constitution of those it attacks. These are cases the physician must study from the social and hygienic standpoint; besides, who can doubt the effects of heredity? The farmer knows that all varieties of seed do not flourish in the same soil and that one must study crops and clay.

At the last Congress on Tuberculosis the more qualified physicians, by authority and their works, said excellent things. But how did their conclusions end? In nothing certain. There was only one agreement—*i. e.,* presidents of South American republics, ministers of state, theatrical journalists, excursionists from the Gold Coast, and even His Serene Highness, the Prince of Monaco, all eminent sanitarians (?) *agreed that sanatoria built at great public expense* were just the things for *specialists in lungs to earn official salaries from.* Great is hygiene, when it creates new positions of medical emolument.

The German (Behring) developed a sensation. He announced *he would cure consumption in* 1906—say by August 1. He might have started on April 1 (Fool's Day) for that matter. He keeps his remedy secret until the date mentioned. Meantime thousands will die, but what difference does that make to such a modern medical savant as Behring in these degenerate professional days, polluted with commercialism. This is the old humbug of laboratory sure cures. The physician of good sense will not fail to recall the furor aroused by Koch's tuberculin. What has become of it? What have become of the doctors, too, who rushed into medical journals early with the claims of many cases cured—that died soon after?

Certainly tuberculosis is curable. No man who has practiced medicine for twenty-five years will fail to recall a few patients who recovered from consumption, but good hygienic surroundings with the grace of God performed these miracles. We know two ladies, one aged 84 and the other 73 years, phthisical for many years, with hemorrhages, night sweats, cough and fever, who still live on, this despite the fact that their sputum is alive with the bacilli. Do you believe, dear confrére, that sanatoria when once created by the State will prevent the development of consumption? If you do, then you are a man of much faith in the modern sensational claims of microbian medicine. Do you believe that large public institutions, mere pretexts for many decorative architects, with expensive medical directors and a brilliant corps of eminent bacteriologists, armed with test tubes, serum, guinea pigs and rabbits, of phthisis? Some thousands of unfortunate consumptives may be immured in such sanatoria, that only wish to admit the incipient cases in order to have a low mortality and a basis on which to found public confidence. But think of the hundreds of thousands of consumptives on the outside who will go on propagating the malady, deemed by many contagious, a belief we do not share in after forty years' practice? Those cases that seek high mountain lands, dry air and a glare of light, no doubt, receive great benefit, but it was Lancey who called such sanatoria, rightly, sanatoria of fortune. Where does phthisis develop if not in the overcrowded tenements of cities, where promiscuity and filth abound. Some streets of Paris, especially those near the market places, are veritable nests for microbes, bacilli and other vermin. Good streets, tenements, drainage and better food for the masses will do more to prevent consumption than the erection of special disease hospitals. It was the legendary Calino who said: "Cities should *be built in the country.*" Behring's new secret remedy need not be mentioned. It will fade like those of the immortal Koch and celestial Marmorek. It is only *human misery that propagates phthisis. "Primo vivere, vide philosophare!"*

Sanitation Up To Date.

"This towel," said the attendant in the germ-proof barber shop, "has been subjected to an extreme heat and is thoroughly sterilized. We take every precaution against exposing our patrons to infection or contagion."

"Good thing," commended the patron.

"This soap," went on the attendant, picking up a cake thereof, "has been debacterialized, and the comb and brush are thoroughly antisepticated."

"Great scheme," said the patron.

"The chair in which you sit is given a daily bath in bichloride of mercury, while its cushions are baked in an oven heated to 987 degrees, which is guaranteed to shrivel up any bacillus that happens along."

"Hot stuff," said the patron.

"The razor and the lather-brushes are boiled before being used, and the lather-cup is dry heated until there is not the slightest possibility of any germs being concealed in it."

"Fine," said the patron.

"The hot water with which the lather is mixed is always double heated and sprayed with a germicide, besides being filtered and distilled."

"Excellent," said the patron.

"Even the floor and the ceiling and the walls and the furniture are given antiseptic treatment every day, and all change handed out to our customers is first wiped with antiseptic gauze. The shoe-polish at the bootblack chair is boiled and then frozen and the——"

"Well, look here," said the patron, who had been sitting wrapped in the towel during all this, "why don't you go ahead and shave me? Think I'm loaded with some kind of germ that you have to talk to death?"

"No, sir," answered the attendant. "But I am not the barber."

"You're not? Where is he?"

"They are boiling him, sir."—(*Illustrated Bits*) *Life.*

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,, Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

Special Meeting Canceled.

The President of the Louisiana State Medical Society has sent the following letter to members:

New Orleans, La., January 15, 1906.

Dear Doctor:

Since issuing a call for a special meeting of the Louisiana State Medical Society, to be held in New Orleans, February 6, 7, 8, 1906, I have become convinced that the project had best be abandoned and the meeting called off.

Recent interviews with members in my own section of the State and correspondence with others have seemed to indicate a lukewarmness and consequent slim attendance, and at a recent conference with officers and members in New Orleans it was decided that the call for the meeing be canceled.

Many members in the parishes would be unable to leave their work at this season, while others who might attend this meeting would be unable to leave again so soon to attend the meeting in May, thereby tending to injure the regular meeting, and it is felt, too, that the need of a special meeting is not now so urgent, for the following reasons:

There is to be no special meeting of the Legislature, the new Board of Health has been appointed and a policy outlined and propaganda of education arranged for by the constituted authorities, making it evident that the Society's advice or counsel will not be required in this direction.

The educational feature, the principal purpose for which the meeting was called, still remains, but this could only be accomplished through a largely attended and enthusiastic meeting, which does not now seem possible.

The idea of a symposium on yellow fever has not been abandoned, but as it is felt that, in consequence of a much larger attendance at the May meeting, more can be accomplished by having it at that time, I have, therefore, decided to cancel the call for a special meeting, and from this time our efforts will be expended upon the regular meeting. Particular attention will be given to the yellow fever feature.

Every member of the Society is urged to begin now to arrange his plans, so as to be present at the meeting to be held at New Orleans on May 8, 9, 10, 1906.

Yours very truly,

C. J. DUCOTE, *President.*

THE AVOYELLES PARISH MEDICAL SOCIETY met in regular quarterly session at Bunkie on January 4, 1906. The meeting was well attended and moves towards urging the police jury to have better roads throughout the parish and radical resolutions were passed condemning the illegal practice of midwifery. The society is determined to put a stop to this latter practice and names will be given the District Attorney for prosecution. If additional legal services are needed the members are pledged to defray the costs. A quarterly per capita tax of $1 was passed by the society, which will be known as the "Entertainment Fund," and will be used to defray the expenses of the social features always attending a meeting. Dr. E. Kiblinger, of Plaucheville, read a well prepared paper on "Specific Urethritis and Complications." It was discussed by Drs. Bordelon, Regard, Couvillion, Davis, Sewall and C. J. Ducote. Dr. P. E. Stanley Matthews, of Bunkie, read a paper on "Scapulo-Humeral Dislocations." It was discussed by Drs. Regard and Couvillion. After a banquet at the T. P. A. Hotel, which was tendered the society by the local profession of Bunkie, the following officers were elected to serve during 1906: President, Dr. W. F. Couvillion, Marksville; Vice-President, Dr. Emile Regard, Mansura; Secretary-Treasurer, Dr. E. Stanley Matthews, Bunkie.

Marksville, April 5, is the place selected as the next meeting place. At this meeting the members are invited to bring their wives, who will be entertained by the families of the local profession of Marksville while the meeting is in session. Two subjects were selected for discussion: For a popular meeting, "Yellow Fever," at which Dr. C. J. Ducoté will open the discussion; for the profession, "The Third Stage of Labor." Dr. E. S. Matthews will prepare a paper and Dr. E. Regard will open the discussion. The following standing committees were appointed: Programme and Scientific Work, Drs. E. Regard and E. DeNux; Committee on Legislation, Drs. C. J. Ducote, T. A. Roy and D. B. Davis. It is expected that a large part of the membership will attend the special yellow fever session of the State Society in early February in New Orleans.

ORLEANS PARISH MEDICAL SOCIETY.

Dr. C. Jeff Miller, President, has appointed the following committees for 1906:

Scientific Essays and Discussions—Dr. Hamilton P. Jones, Chairman; Dr. S. K. Simon; Dr. L. Perrilliat, Dr. C. W. Allen, Dr. J. A. Danna, Dr. R. M. Van Wart.

Judiciary—Dr. Isadore Dyer, Chairman; Dr. B. A. Ledbetter, Dr. Jules Lazard, Dr. E. J. Graner, Dr. A. B. Brown, Dr. W. G. Armstrong.

State Medicine and Legislation—Dr. J. M. Batchelor, Chairman; Dr. A. Nolte, Dr. S. L. Theard, Dr. F. A. Larue, Dr. P. E. Archinard, Dr. W. T. O'Reilley, Dr. O. Joachim.

Library—Dr. Homer Dupuy, *ex-officio,* Chairman; Dr. L. C. Chamberlain, Dr. W. H. Seemann, Dr. E. O. Trahan, Dr. J. Barnett, Dr. Paul J. Gelpi.

Publication—Dr. Amédée Granger, *ex officio,* Chairman; Dr. George S. Bel, Dr. E. W. Walet.

President's Address—Dr. E. W. Jones, Chairman; Dr. C. N. Chavigny, Dr. L. L. Cazenavette, Dr. Felix Formento.

Secretary's Report—Dr. W. T. Richards, Chairman; Dr. C. Wm. Groetsch, Dr. Edmund Moss, Dr. D. L. Watson.

Treasurer's Report (Auditing Committee)—Dr. P. L. Thibaut, Chairman; Dr. W. H. Robin, Dr. J. N. Roussel, Dr. Philip Asher.

Necrology—Dr. A. Weber, Chairman; Dr. A. McShane; Dr. W. G. Troescher, Dr. E. M. Dupaquier.

Librarian's Report—Dr. Gustav Keitz, Chairman; Dr. R. J. Mainegra, Dr. M. M. Lowe, Dr. C. F. Sauter.

ELECTION OF OFFICERS.

Claiborne Parish Medical Society met at Homer, January 9, 1906, and elected the following officers: President, Dr. L. T. Waller, Haynesville; Vice-President, Dr. J. T. Simpson, Athens; Secretary-Treasurer, Dr. J. E. Knighton, Homer. Dr. Simpson read an excellent paper on "Bronchopneumonia," which was discussed interestingly by those present. The Claiborne Parish Medical Society is prosperous and progressive, there being only two eligible physicians in the parish who are not members.

Assumption Parish Medical Society held its annual meeting at Napoleonville January 11, 1906. The following officers were elected: President, Dr. A. J. Himel, of Napoleonville; Vice-President, Dr. W. E. Kittredge, of Napoleonville; Secretary-Treasurer, Dr. A. A. Landry, of Paincourtville. Interesting papers were read. Dr. T. B. Pugh spoke on "Normal Labor." Dr. T. B. Pugh spoke on the subject and the discussion was opened by Dr. Fulton Rogers. The society then adjourned to a sumptuous banquet at the F. Dupaty House, where a good time was had by all present.

Medical News Items.

THE LOUISIANA STATE BOARD OF HEALTH was reorganized with the following membership on January 8: President, Dr. C. H. Irion, New Orleans; Vice-President, Dr. W. G. Owen, White Castle; members, Dr. G. W. Gaines, Tallulah; Dr. A. J. Perkins, Lake Charles; Dr. T. E. Schumpert, Shreveport; Dr. J. M. Batchelor, New Orleans; Dr. W. G. Armstrong, New Orleans, and W. S. Ingram, Secretary, New Orleans. The central office of the Board will continue at 204 Carondelet street, New Orleans, La.

THE THIRD INTERNATIONAL MEDICAL CONGRESS OF ELECTROLOGY AND RADIOLOGY will be held at Milan, from September

5 to 9, 1906. Later advice will make known the details of the meeting.

THE OBSTETRICAL SOCIETY OF PHILADELPHIA HAS ELECTED THE following officers for 1906: President, Wilmer Krusen, M. D.; Vice-Presidents, F. Hurst Maier, M. D., and G. M. Boyd, M. D.; Secretary, Frank C. Hammond, M. D.; Treasurer, J. W. West, M. D.; Curator, B. M. Anspach, M. D.

TRIED FOR SELLING PATENT MEDICINES WITHOUT A LICENSE.—At Meridian, Miss., on January 4, two men giving their residence as Ohio were tried before Justice Townsend for selling patent medicines without a license and were fined $50 and costs.

RESOLUTION ADOPTED BY THE JONES COUNTY MEDICAL SOCIETY.—At Ellisville, Miss., the Jones County Medical Society, at a meeting held on January 11, adopted a resolution ordering a petition sent to the lawmakers in session at Jackson asking the Legislature to compel all manufacturers of patent and proprietary medicines sold in the State to print the formula of ingredients on each bottle.

EFFORTS OF THE BOARD OF HEALTH OF LAKE CHARLES TO IMPROVE SANITATION.—The Board of Health of Lake Charles in its efforts to improve the general sanitary condition of the city has been backed up by the Fifteenth Judicial District Court by a judgment rendered by Judge E. D. Miller in favor of plaintiff in the condemnation suit brought to compel David Bloch to remove a building on the ground that it was unsanitary and a menace to public health.

THE NEXT MEETING OF THE ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE will be held in New York on December 27, 1906. The following officers were elected at their last meeting, held in this city December 29 to January 4: President, William H. Welch, of Johns Hopkins University, Baltimore, Md.; General Secretary, John F. Hayford; Secretary of Council, F. W. McNair.

THE ASSOCIATION OF SCIENTISTS AT ITS LATE MEETING IN THIS CITY passed the following resolution: "That we heartily indorse the efforts of the Committee of Manufacturers, which was formed to assist in securing cheaper alcohol for industrial purposes, in their work in urging the passage of an act, through Congress, providing for the sale of tax-free alcohol under proper restrictions, and that we recommend that the widest publicity be given to this expression of our views."

AT THE LAST MEETING OF THE HINDS COUNTY MEDICAL SOCIETY, held at Jackson, Miss., there were three new members elected.

THE FOLLOWING OFFICERS WERE ELECTED at the last meeting of the Madison County Medical Society, Alabama: Dr. Felix Baldridge, President; Dr. B. E. Graham, of Curley, Vice-President; Dr. M. R. Moorman, of Huntsville, Secretary and Treasurer; Dr. T. L. Mastin, Censor; Dr. W. G. Wheeler, County Health Officer.

THE FRANKLIN PARISH MEDICAL SOCIETY met at Winnsboro, La., January 9, and elected the following officers for the ensuing year: President, Dr. L. M. Griffin, of Oakley, La.; Vice-President, Dr. C. L. Ramage, of Winnsboro, La.; Secretary and Treasurer, Dr. H. B. Womble, of Gilbert, La.

NEW APPOINTMENTS BY THE STATE BOARD OF HEALTH.—Dr. S. G. Gill, former Shipping Inspector, will succeed Dr. J. Hope Lamb at Port Eads. Dr. Lamb will move to Quarantine Station to take the place made vacant by the death of Dr. Aby. Dr. H. A. Veazie will take Dr. S. G. Gill's place.

Colonel W. S. Ingram has been elected Secretary in place of Dr. G. Farrar Patton, resigned. Dr. J. Fred Mayer, of Scott, La., has been made Special Medical Inspector. Dr. C. Milo Brady, re-elected State Medical Inspector. Dr. A. L. Metz, State Chemist.
re-elected State Medical Inspector. Dr. A. L. Metz, State Chemist,
Dr. P. E. Archinard, State Bacteriologist.

PERSONALS: Dr. William Osler has returned to America for a short time and will do some work at Johns Hopkins University this winter.

Dr. Louis Crawford is now Assistant Resident Physician at the New Orleans Sanitarium in place of Dr. J. D. Martin, resigned.

Dr. Wallace J. Durel has returned to his sanitarium in Covington after a three months enforced stay in this city, due to a fractured femur.

Dr. R. C. Lynch has left Natchitoches, La., and will spend a year in post-graduate work.

Dr. P. E. Bechet has left this city and is now located at Natchitoches, La.

Dr. R. H. Gulledge has left Belcher and bought out the drug business of Dr. C. H. Irion at Benton, La.

Dr. E. M. Hummel has been made First Assistant Superintendent at the Insane Asylum at Jackson.

Dr. H. L. Ducrocq, of Lafourche Crossing, has moved to Lafayette, La., where he will be permanently located.

REMOVALS: Dr. W. W. Duson, from Crowley, La., to Campo, Tex. Dr. W. H. Wagley, from Livonia to Maringouin, La. Dr. J. D. Calhoun, from Homer to Mansfield, La. Dr. T. N. Keoun, from Red Land to Plain Dealing, La. Dr. A. M. Haralson, from Taylorville to Sylvarena, Miss. Dr. W. W. Burkhalter, from Wakefield to Laurel Hill, La.

RECENT VISITORS TO NEW ORLEANS: Among the visiting doctors to the city last month were: Dr. J. T. Bringier, of Burnside, La.; Dr. F. H. Thompson, of Bogue Chitto, Miss.; Dr. C. E. Catchings, of Woodville, Miss.; Dr. Theo. Engelbach, of Grand Isle, La.; Dr. J. T. Crofford, of Memphis, Tenn.; Dr. G. W. Sims, of Assumption Parish, La., and Dr. L. O. Howard, of Washington, D. C.

MARRIED: On December 13, 1905, Dr. Waldemar T. Richards was married to Miss Jessie Ross Cotter, of La Grange, Ga.

Dr. N. S. Leyland, of Woodville, Miss., to Miss Roberta Munson, of Hope Villa, Bayou Manchac, La., on December 22, 1905.

DIED: On November 27, 1905, Dr. J. E. Thomson, of Delhi, La., died of acute appendicitis. He was a graduate of Tulane

Medical College in 1901 and of the Chicago College of Pharmacy in 1895.

Dr. V. M. Neal, one of the leading physicians of the County of Forest, Miss, died on December 20, 1905. Dr. Neal was about 70 years of age and had been practicing medicine for twenty-five years.

Dr. B. W. Inman, at Leota Landing, Miss., died on December 11, 1905. The doctor spent the winter in New Orleans two years ago and attended the New Orleans Polyclinic.

On December 24, 1905, Dr. Thomas Y. Aby, at the age of 65 years, and one of the best-known physicians in this State, died at his residence in New Orleans after an illness which had lasted for over a year. Dr. Aby has held many important positions, the most recent of which was that of Assistant Quarantine Surgeon, which position he filled until last October, when his health failed.

Book Reviews and Notices.

All new publications sent to the Journal *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* Journal *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Diseases of the Heart. A Clinical text-book for the use of students and Practitioners of Medicine, by Edmund Henry Colbeck, B. A., M. D., B. C. (Cantab), F. R. C. P. (London), D. S. H. (Cantab), etc., etc., with forty-three illustrations. 2nd Edition revised and enlarged. W. T. Keener & Co., Chicago, 1905.

This book deals with the elementary and fundamental bedside features of cardio-vascular disease, in other words the clinical side of the subject of heart disease, in a form suitable to the requirements of the student and newly qualified practitioners, presented in a concise and systematic manner. Controversial matter has to a large extent been avoided, permitting of much greater precision in the exposition of the subject. New matter has been added, viz.: account of mechanical strain of the heart and of the Stokes-Adams' syndrome. The treatment of chronic valvular disease has been amplified. The instrumental determination of blood pressure, which seems likely to occupy a prominent place in the clinical investigation of cardio-vascular disease, has received but scant consideration, since, at present and so far, it appeared hardly profitable to enter into a detailed description. The illustrations are very good.

E. M. D.

Progressive Medicine. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by HOBART AMORY HARE, M. D., assisted by H. R. M. LANDIS, M. D. Lea Brothers & Company, Philadelphia and New York

This volume (II), June, 1905, contains extensive reviews on the subject of Hernia by William B. Coley, M. D., of the Surgery of the Abdomen, exclusive of Hernia by Edward Milton Foote, M. D., of Gynecology by John G. Clark, M. D., of the Diseases of the Blood, Dietetic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland and Lymphatic System by Alfred Stengel, M. D., and of Ophthalmology by Edward Jackson, M. D. The yearly four volumes of this great quarterly form, when put together, a mass of information which makes this publication a formidable competitor in the field of annuals. E. M. D.

Eleventh and Concluding Volume of the "System of Physiologic Therapeutics." Edited by PROF. SOLOMON SOLIS COHEN. Messrs. P. Blakiston's Sons & Co., Philadelphia, 1905.

This volume treats of the newest developments in the art of medicine, the use of antitoxic and bacteriolytic serums, extracts of organs, internal secretions, radium, X rays, etc. The editor sets forth the underlying principles of therapeutics, laying especial stress on the biological relations of medical problems and the importance of the physical and chemical components of vital reactions. The article is a condensation and summary of his original teachings on this subject as embodied in his lectures at Jefferson Medical College and Dartmouth Medical College and in addresses before various medical associations.

An Index-Digest of more than 100 pages furnishes an epitome of the practical teachings of the eleven volumes, arranged for facility of reference under headings of Diseases and Significant Symptoms (as Cough, Fever, Jaundice, Rheumatism, Tuberculosis, Typhoid, etc.), giving brief memoranda of the various methods of treatment applicable, and referring to the volume and page where more elaborate discussion is found. Great care has been given to the preparation of this index and over three months was required for the careful verification of all the references and for thorough proofreading. Its great value will be appreciated by the thousands of physicians who are purchasing this monumental work, of which one journal said that it signified the dawn of a new era in therapeutics. E. M. D.

Acute Contagious Diseases, by WILLIAM M. WELCH, M. D., and JAY F. SCHAMBERG, A. B., M. D., of Philadelphia. Published by Lea Brothers & Co., Philadelphia and New York, 1905. Illustrated with 109 engravings and 61 full-page plates.

This is a practical treatise for the guidance of students and practitioners of medicine on a small group of diseases, particularly those with which the authors have had experience in the Municipal Hospital of Philadelphia—smallpox, chicken-pox, scarlet fever, measles, rubella, typhus fever, diphtheria—all of which are distinguished by great transmissibility. Vaccinia is extensively considered, though, of course, it is not contagious, but its relation to the prophylaxis of smallpox makes the consideration of the two inseparable. The amount of space devoted to smallpox, and particularly to its diagnosis, is capital. This special work is a most commendable one. E. M. D.

International Clinics. Vol II. Fifteenth Series. A Quarterly of illustrated Clinical Lectures, etc. Edited by A. O. J. KELLY, A. M., M. D. J. B. Lippincott Co., Philadelphia and London, 1905.

This interesting volume contains the treatment of Acute Nephritis in Childhood, by John Lovett Morse, M. D.; the Therapeutic Indications of Kephir, by G. Hayem, M. D.; Some Observations on the Treatment of Pulmonary Hemorrhage by Adrenalin Chlorid, by D. Barty King, of Edinburgh; Suggestions Regarding the Treatment of Neurasthenia, by Robert T. Edes, M. D.; X-Ray Treatment of Tinea Tonsurans, by Drs. Sabouraud and Noire; the Diagnosis of Incipient Thoracic Tuberculosis, by Robert N. Willson, M. D.; Uremic Psychosis, Multiple Gastric Ulceration, Diabetes Mellitus, by Solomon Solis Cohen, M. D.; Galloping Typhoid Fever, by H. Roger, M. D.; Plague, by J. Rutter Williamson, M. D., of Edinburgh; Seasickness, with Special Reference to Its Pathogeny, by A. L. Benedict, M. D.; the Pathology and Treatment of the Hernias of Children and Their Relation to Conditions in the Adult, by Edred M. Corner, M. B., B. Sc., F. R. C. S.; Injuries of the Prostate Gland, by G. Frank Lydston, M. D.; Enlargements of the Testis and Epididymis, by Daniel N. Eisendrath, M. D.; Acute Purulent Generalized Meningitis, by Drs. Lermoyez and Bellin; Clinical Notes on Intracapsular Fractures and Dislocations at the Hipjoint, by the late Thomas H. Manley, M. D.; Traumatism as an Etiologic Factor in Infectious Diseases of the Bones and Joints, by Greene Caneston, M. D.; Sarcoma of the Gluteal Region, Epithalioma of the Leg, Angioma of the Lower Lip, by Garland Sherrill, M. D.; the Use of Scopolamine as a General Anesthetic in Surgery, by Felix Terrier, M. D.; the Rational Therapy of Uterine Displacements, by Chauncey D. Palmer, M. D.; the Clinical Significance of Exophthalmos, by Mary Buchanan, M. D.; the Symptoms and Diagnosis of the Suppurative Diseases of the Accessory Sinuses of the Nose, by Norval H. Pierce, M. D.; Some Physiologic Aspects of Ehrbich's Side-Chain Theory and Its Application to the Physiology of Digestion, by John C. Hemmeter, M. D.; the Anatomy, Physiology and Pathology of the Chromoffin System, with Special Reference to Addison's Disease and Status Thymicus, by Joseph Wiesel, M. D. E. M. D.

The Diagnostics of Internal Medicine, by GLENTWORTH REEVE BUTLER, Sc. D., M. D. D. Appleton & Co., New York and London.

This book, which has now passed to a second edition, embraces practically all knowledge which is essential in the making of a diagnosis, and any clew which might be of value in obscure cases receives due consideration.

From the standpoint of physical diagnosis it leaves little to be desired, the text being accurate and concise and the illustrations by Howard J. Shannon being highly artistic. Modern laboratory methods receive their full quota of attention.

Plates III and IV are composed of selections reproduced from the excellent illustrations in Cabot's "Examination of the Blood" and Simon's "Clinical Diagnosis." Plate V consists of similar selections from Thayer's drawings of the malarial parasite.

The volume is divided into two parts. First, a study of symptoms and their indications; and, second, a study of diseases and their characteristics. We wish to commend this arrangement as a happy one.

No man can become a good diagnostician merely by the reading of books and the study of diagrams and illustrations, but one's knowledge of clinical methods can be increased by the study of such a book as this, and it naturally follows that the more thorough one's knowledge of clinical methods becomes the better diagnostician one will be. STORCK.

Therapeutics; Its Principles and Practice, by Horatio C. Wood, M. D., LL. D. J. B. Lippincott Co., Philadelphia and London, 1905.

American medicine is under many obligations to Horatio C. Wood, a Nestor in the field of the scientific investigation of the action of drugs on the animal economy. All physicians must recognize in the man the careful and conscientious investigator and physician. His work has embodied his own observations and teachings, which have ever been sound and safe. The present twelfth edition is a masterpiece of medical literature. Since 1875 this work has been before the medical profession of America and Europe and has met with remarkable favor. Why? Because it has merit. The present edition has been made to conform closely to the 1900 Pharmacopœia and other important additions have been made. The chapters on Expectorants and on Disinfectants have been completely rewritten, and new, systematic classifications of these drugs adopted. Chapters on Spinal and Neural Anesthesias have been added. Among the new drugs added may be mentioned: Veronal, theocine, lecithin, collargol, tetranitrate, nexine, creosotal, erythrol, hetol, bismutosa, gelatin, sarol, quinic acid, thiosinamine, hedonal, agurin, oxycamphor glosote, apocynum, argyrol, airol, lysol, anæsthesin, ispral, urotropin, theocol, hydrofluoric acid, phrosal, urasol, belmitol, nervanin and tachiol.

This work is so arranged that the student will find it handy as a textbook and the practitioner as a reference work.

We would like to see this work in the hands of every student and in the library of every practitioner of medicine. Storck.

Manual of Chemistry, by W. Simon, Ph. D., M. D. Lea Brothers & Co., Philadelphia and New York, 1905.

Simon's Manual of Chemistry needs no introduction to students of this science in the United States. Since the issue of the first edition it took front rank with works of its kind and has maintained its standing ever since.

The present edition embodies the changes and additions to the 1900 United States Pharmacopœia and has been revised and brought abreast of our present-day knowledge of chemistry. "An alteration has been made in the colored plates in order to introduce one giving the color changes of the most important indications used in volumetric analysis of the gastric juice."

Brief descriptions are given of the principles which lead to an understanding of some instruments used in chemical operations, such as investigations with the spectroscope and polariscope.

Electrolysis and the ionic theory are briefly but lucidly considered from a modern standpoint. The beginner, as well as the advanced student, will find this volume a safe and valuable guide. We know of none better. Storck.

A Manual of Chemistry—Inorganic and Organic, for the Use of Students of Medicine, by Arthur P. Luff, M. D., B. Sc., F. R. C. P., F. I. C., and Frederic James M. Page, B. Sc., F. I. C. W. T. Keener & Co., Chicago.

This excellent little work, written by those who know the needs of medical students and who have been careful to give them that which they most need, should find a ready reception by them. Storck.

Materia Medica and Pharmacy, by R. B. Wilcox, M. A., M. D., LL. D. P. Blakiston's Sons & Co., Philadelphia, 1905.

The present volume is based upon the fifth edition of White and Wilcox's "Materia Medica, Pharmacy, Pharmacology and Therapeutics."

It embodies the alterations and additions of the new United States Pharmacopœia. The classification followed is in accordance with the natural order. In the companion volume, "Pharmacology and Therapeutics," the classification followed is in accordance with the uses and physiological action of the drug.

The author has modeled the present volume along lines agreeing with the most modern methods of teaching in order that it may forcibly appeal to teachers and students of medicine. STORCK.

Publications Received.

P. Blakiston's Son & Co., Philadelphia, 1905-06.

A Compend of Medical Chemistry, by Henry Leffman, M. D., 5th Edition.

Materia Medica for Nurses, by John E. Groff, Ph. G. 3rd Edition.

Quiz Compends. A Compend of Diseases of the Skin, by Jay F. Schamberg, A. B., M. D. 4th Edition.

The Management of a Nerve Patient, by Alfred T. Schofield, M. D.

Pharmacology and Therapeutics, by Reynold Webb Wilcox, M. A., M. D. 6th Edition.

G. P. Putnam's Sons, New York and London, 1905.

Life and Matter, by Sir Oliver Lodge.

E. B. Treat & Co., New York, 1905.

Man and His Poisons, by Albert Abrams, A. M., M. D.

D. Appleton & Co., New York and London, 1906.

Differential Diagnosis and Treatment of Disease, by Augustus Caille, M. D.

Lea Bros. & Co., Philadelphia and New York, 1906.

Food and Diet in Health and Disease, by Robert F. Williams, M. D.

A Manual of Materia Medica and Pharmacology, by David M. R. Culbreth, M. D., 4th Edition.

Miscellaneous.

Clinical Obstetrics, by Robert Jardine, M. D. (Rebman Co., Ltd., New York and London, 1905.)

Report of the Department of Health of the Isthmian Canal Commission for the Month of October, 1905. Colonel W. C. Gorgas.

Report of the Chief Quarantine Physician of Louisiana of the Operations of the Louisiana Quarantine During the Yellow Fever Epidemic of 1905. Made to Hon. Newton C. Blanchard.

A Trip to the "Land of the Midnight Sun," by Flavel B. Tiffany, M. D. (Hudson Press, Kansas City, 1905.)

Reprints.

The Office Treatment of Diseases of the Rectum, etc., by Charles B. Kelsey, M. D.

The Destiny of the American Negro, by H. L. Sutherland, M. D.

Word-Blindness, With the Record of a Case due to a Lesion in the Right Cerebral Hemisphere in a Right-Handed Man, etc., by Charles K. Mills, M. D.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR DECEMBER, 1905.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	2	1	3
Intermittent Fever (Malarial Cachexia)	1	1	2
Smallpox	....	....	....
Measles	....	....	....
Scarlet Fever	....	....	....
Whooping Cough	1	....	1
Diphtheria and Croup	2	....	2
Influenza	1	3	4
Cholera Nostras	1	....	1
Pyemia and Septicemia	2	....	2
Tuberculosis	46	47	93
Cancer	12	6	18
Rheumatism and Gout	1	1	2
Diabetes	2	....	2
Alcoholism	6	....	6
Encephalitis and Meningitis	5	3	8
Locomotor Ataxia	3	....	3
Congestion, Hemorrhage and Softening of Brain	19	12	31
Paralysis	4	6	10
Convulsions of Infants	1	3	4
Other Diseases of Infancy	17	12	29
Tetanus	3	6	9
Other Nervous Diseases	2	1	3
Heart Diseases	42	28	70
Bronchitis	7	1	8
Pneumonia and Broncho-Pneumonia	27	18	45
Other Respiratory Diseases	6	4	10
Ulcer of Stomach	....	1	1
Other Diseases of the Stomach	2	3	5
Diarrhea, Dysentery and Enteritis	28	13	41
Hernia, Intestinal Obstruction	3	1	4
Cirrhosis of Liver	4	1	5
Other Diseases of the Liver	2	1	3
Simple Peritonitis	2	....	2
Appendicitis	3	1	4
Bright's Disease	26	24	50
Other Genito-Urinary Diseases	5	4	9
Puerperal Diseases	4	4	8
Senile Debility	16	12	28
Suicide	7	....	7
Injuries	16	19	35
All Other Causes	26	1	27
TOTAL	357	238	595

Still-born Children—White, 23; colored, 18; total, 41.

Population of City (estimated)—White, 245,000; colored, 88,000; total, 333,000.

Death Rate per 1000 per annum for Month—White, 17.92; colored, 33.20; total, 21.96.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**30.12**
Mean temperature	**51.**
Total precipitation	**14.43 inches.**

Prevailing direction of wind, north.

New Orleans Medical and Surgical Journal.

VOL. LVIII. MARCH, 1906. No. 9

Original Article.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints may be had at reasonable rates if a **Written** order for the same accompany the paper.)

Remarks on Melancholia.

By DR. E. M. HUMMEL,

Assistant Physician, Louisiana State Insane Asylum, Jackson, La.

Those engaged in intimate study of mental affections are no longer contented to occupy themselves so much with an hallucination or delusionary misconcept, which phenomena are now properly regarded as mere incidents peculiar to individual cases, but rather is the attempt made to penetrate more deeply to the substrata of fundamental psychological principles or biologic laws of the mental personality. It is true that the first objectively noticeable symptoms of a given mental attack are frequently detected in the little pranks played with the faculties of refined mental activity, but when too much stress is placed upon these, erroneous conclusions are inevitably drawn. Only by directing attention to the more instinctive qualities of organic mental life, endowments of the race rather than the peculiarity of any respective individual, do we derive useful information to help in the distinction and treatment of cases. Such qualities are constant and alike in all sane people, and the phenomena of insanity, strange and diversified as they truly are, when thus regarded, arrange themselves in certain large groups according to the manner in which one or several of the basic mental attributes are involved. Kraeplin's classification, or more correctly his methed of analysis or diagnosis, being founded upon these principles, has the firmest hold upon the minds of students of modern psychiatry.

In these brief remarks on melancholia let us see in what most essential or fundamental way the mentality has been distorted. It is scarcely necessary to mention that melancholia means depression, but practical experience will readily demonstrate that even simple depression is not so easy to distinguish, and, further, that there are several kinds of depression having widely diverse significance, which if we fail to interpret, we will be utterly misled in our further judgment of the case. We see great numbers of patients presenting apparent depression, nevertheless true melancholia is comparatively rare, and its supposed frequency is made apparent by the confusion existing in the average medical mind as to what constitutes the disease. Dementia præcox has a stuporous stage, but there is simply an emotional indifference—and apathy is not depression, though it may be mistaken therefor. In the depressive stage of circular or maniacal-depressive insanity there really exists a depression of the spirits, but it is never very deep, and the condition is chiefly characterized by impediment to psycho-motor operations, together with its alternations with mania. Depression is sometimes found in the early stages of paresis, but the physical signs accompanying the latter will set us right. States of amentia with bewilderment, and even dementia, are sometimes misinterpreted as depression. These and other forms of insanity are often mistaken for the condition under discussion. True melancholia is pre-eminently a disease of the emotional realm. Comprehension, memory, orientation, judgment, interpretation of common sensation, are all good considering the depth of the emotional reduction. The picture presented is that of morbid accentuation of those anxieties sane people experience within measured bounds. The apprehensive sense, a refined form of fear, is a normal and useful instinct, but if it be morbidly intensified the subject suffers mental dissolution and delusions are projected upon the screen of consciousness. Certain people inherit a bilious temperament, and acquire specific habits of worry. We would consider such a one predisposed to melancholia, and the apprehensive peculiarity will likely determine the subject of the delusive concept, if such develop during the attack. A patient of previous religious cast has committed the "unpardonable sin"; the one accustomed to business worry has been financially ruined; another sensitive about his physical well-being takes a hypochondriacal turn. The delusions themselves mean nothing, it is their color which is significant, and they are such because emotional depression is permeating the whole picture. The patient's gloomy outlook from the subjective view-point, lamentations and apprehensive anxiety are of the same significance. To reiterate, the underlying psychopathic state is morbid emotional depression in which the instinctive trait of apprehension participates more conspicuously. Its physical basis is held to be some state of inadequacy. Many things point that way. The symptoms are commonly more intense in the early waking hours, due probably to tardiness in completion of the vascular circuit of the brain, from vaso-motor torpor, after physiological depletion accompanying sleep. The somatic functions are usually poor preceding the attack. More important still, melancholia is notoriously a disease of old age, and it hovers around the period of the climacteric in both sexes with a significant persistency. Cessation of the reproductive function marks the beginning of old age. Upon the occurrence of this episode of involution a tremendous prop to the vital powers is removed. There is no mitigating this, nature is never very kind or partial to a sterile organism. Even under normal circumstances customary animation abates, and the person glides uneventfully into the mild apathy characteristic of beginning senility. There being only a short step from apathy to depression, psycho-neurotic tendencies find their expression in melancholia. While external events may precipitate the attack the most abiding and true cause is hereditary bias, provoked by the critical epoch of involution. These remarks are at least pertinent to those cases occurring in advanced age. Vascular degeneration at this time doubtless plays a part also.

TREATMENT—Of all those so unfortunate as to become affected mentally melancholics are entitled to most sincere sympathy and consideration, especially at the hands of the physician, because they suffer most acutely. Great palliation of the psychalgia incident to the tedium of intense emotional depression and apprehensive pain with agitation can be accomplished with opium. The drug should be exhibited in small doses gradually increased until the symptoms are relieved, and then withdrawn. Psycho-motor restlessness is benefited by the prolonged hot bath or pack. Sleep may be thereby induced. Insomnia which is sometimes persistent usually yields to mild hypnotic drugs, as paraldehyde. The digestive function, almost always torpid, should be stimulated, and sodium phosphate should usually figure in the prescription. Much else can be done on symptomatic lines, but the measure is not an unusual one and suggests itself. Prognosis is good in the larger number of cases, though the course of the illness is frequently protracted, interrupted by relapses, and not uncommonly is there a permanent emotional dullness after an otherwise fair recovery. Owing to the paramount tendency of this class of patients to harm themselves, attempts at suicide must be anticipated and guarded against.

Louisiana State Medical Society Proceedings.

(EDITED BY PUBLICATION COMMITTEE).
P. L. Thibaut, M. D., Chairman.

MORNING SESSION, THURSDAY, MAY 11, 1905, 9:30 O'CLOCK.

SECTION ON BACTERIOLOGY.

DR. JOHN J. ARCHINARD, Chairman, read a paper on *Serums, Toxins and Vaccines as Aids to Diagnosis and Treatment.*
(Paper not furnished.)

DISCUSSION.

DR. DUREL: I think that the tuberculin test is in greater use than ever. By close observation we can diagnose early cases of tuberculosis by the physical signs, but there are some cases where it is very difficult, and sometimes impossible. I read a paper before the Orleans Medical Society, two months ago, in which the above was discussed. I have never had a positive case of tuberculosis that did not respond to the tuberculin test!

The question as I look at it is this: When we see the large number of patients that come to us in the third and fourth stages of tuberculosis, without having been diagnosed when in the primary stages, we must evidently conclude that, even if the tuberculin test did seem to do harm in a few reported cases, it is better to give these cases a chance of an early diagnosis. I think that it is a great deal better to make use of it, in these early cases, so that we can make diagnosis in the very earliest stage of the disease. It is important that we diagnose our cases as early as possible, as we have great hopes for the recovery of these cases.

If there is anything to be done, it must be done in the early stages. Regarding the therapeutic use of tuberculins or culture products in tuberculosis, I will say that the preparation I have used was Von Ruck's watery extract of tubercle bacilli. The results from the use of this preparation have not been satisfactory in the hands of some; but these expected too much, and disregarded other important measures, to be used in addition to the watery extract. The results from the use of only one single remedy in any disease cannot be satisfactory (more so in tuberculosis) without the aid of hygienic, dietetic and other measures. We cannot rely upon any exclusive remedy in any disease. Tuberculin is without doubt a very important addition in the diagnosis of tuberculosis; and in the treatment of tuberculosis, though we do not get all the results that we desire from its use, we do get some good results. While it is imperfect it leads to some promise, and we ought to use it.

Dr. Guthrie: It is of great value as a diagnostic measure. In regard to the use of the culture products as therapeutic agents I would disagree with him, so far as my experience goes. Some years ago I obtained a résumé of the experience of the physicians of Asheville, and they assured me that their results were identical —no better and no worse—than the results obtained by Von Ruck in his sanitarium. They said that their results were obtained by hygienic and dietetic treatment entirely. I have heard the statement made by the doctor himself that he does not use the culture products.

Dr. Weis: I wish to speak about tuberculin as a diagnostic agent. I think that it is a very valuable adjutant in the diagnosis of obscure tubercular infection. In regard to tuberculin T. R., I know that it is prepared in a large sanitarium in Massachusetts.

Dr. J. F. Oechsner: The importance of this subject will be realized if we stop to think that medicine of the future will lie much along the lines of serum-therapy. All must agree on its diagnostic value, not alone in pulmonary tuberculosis, but in the diagnosis of tuberculosis generally, wherever located. Dr. Baer, of Johns Hopkins, has recently written a very interesting and instructive article on the value of tuberculin in the diagnosis of tubercular conditions in orthopedic surgery. In many cases positive findings were made in the face of negative clinical evidence, verified subsequently by skiagraphs and the determination of the disease on the operating table, and *vice versa,* negative findings in the face of seemingly evident clinical symptoms of tuberculosis.

We must be unprejudiced in trying to determine the value of these preparations. It is a question whether or not the happy results mentioned by Dr. Durel were due to the use of the watery extract of tubercle bacilli or the forced feeding, as demonstrated by Russell, of New York. Russell's results seem to compare favorably with those obtained by the use of tuberculin or watery extract of tubercle bacilli. Undoubtedly, judiciously and scientifically used, some value must attach to tuberculin and the watery extract of tubercle bacilli. With serum-therapy so promising, we must guard against the tendency of manufacturers to thrust on the market various serums which have not been tested scientifically. If we exclude anti-tetanic serum as a prophylactic and antidiphtheritic serum, there is probably today no other serum upon which absolute reliance can be placed.

Dr. Fenner: I have had some experience with tuberculin as a diagnostic agent. I was unable to hear Dr. Archinard's paper.

I believe that tuberculin has very decided value. At least, it has been so indicated in the cases in which I have been able to use it, and of which I hope to be able to make a report.

Dr. Granger: I saw a case in which serum had been used in a case of carcinoma. It did no good, and I think it did harm. As to the treatment of this condition, I wish to take issue with Dr. Archinard when he says that the knife is the only way. Last year I treated a number of cases by the Massey method of cataphoresis. One case has been well for eighteen months; one for fifteen months, and one for one year.

Dr. Durel: When I developed tuberculosis I thought what was to be done—whether I was to go West and rough it out, or stay South. I went to Asheville, N. C. I have seen hundreds of cases while there, and none of these cases were doing as well as those cases treated in sanitariums and with culture products by Ambler, Von Ruck and others. Weaver, of Asheville, does use culture products, as seen in the report of his cases. What I am telling you is not what I have heard, but what I have seen with my own eyes.

I would not deceive you. I have been a victim, and have been benefited by the watery extract, and I am proud to proclaim it. I kept up the watery extract for two years. I know positively that I have not relapsed, for I have gained thirty-six pounds since I was cured, and that has been four years since.

Dr. J. F. Oechsner: I believe that the Society should put itself on record in some way. The value of the antidiphtheritic serum has been demonstrated, but I believe that we should put ourselves on record by resolution that we deprecate the putting on the market wholesale serums which have not been proven of value.

Dr. Durel: If tuberculin as a test for tuberculosis does harm, please state in what cases it does harm. Is it in those who have tuberculosis, or in those who do not have it?

Dr. J. J. Archinard (in closing): I wish to say that it is not an invaluable test. Very often you get no results at all. I have been just as enthusiastic as any of you. I agree with what has been said about diet. The diet is of the greatest importance. Dr. Grouche's method has not yet passed the experimental stage.

In what cases have I known them to do harm? I have known them to do harm in cases of tuberculosis in the secondary stage—also in lupus.

DR. J. BIRNEY GUTHRIE read a paper on:

Blood Smears: A Simple Method of Preparation—Their Diagnostic Value.

I am prompted to the selection of the above title because of the wide field of application of this method of microscopic examination. The preparation of blood smears for examination and the staining of the same for examination present few difficulties since the adoption of the method of smearing the blood directly on the slide, and the subsequent employment of Wright's modification of Leishmann's double stain. The method of preparing the smears is briefly as follows:

Two ordinary microscopic slides with ground edges are thoroughly cleaned; first with soap and water and then with alcohol to insure freedom from grease. A medium sized drop of blood is obtained from the lobule of the ear and dropped near the end of slides. This is placed on a table and the end of the other slide is placed in it and held for a few seconds until, by capillarity, the drop has run over one lateral edge to the other of the second slide. Then the second slide, which is held at an angle of about thirty degrees to the first, is drawn slowly across the face of the first. Then, reversing the procedure, a second preparation is made on the other slide. The two resulting smears are allowed to dry in the air and are now ready for the stain.

The above technic in preparing blood smears has the advantage of being easily acquired. I have satisfied myself of this fact after having spent weeks as a medical student in 1898 in making blood smears by other methods, using cover slips, and in using lens paper as a spreader. I also find in my clinical teaching that students who have never seen a blood smear made can make satisfactory smears immediately after having seen a demonstration of this method.

The smears so obtained are stained whenever convenient by the Wright method, which was described by Wright in the *Journal of Medical Research,* January, 1902. A description of this stain and the technic of employing it may be found also in two of the standard text-books, Boston's *Clinical Diagnosis* and Cabot's *Clinical Examination of the Blood.*

I have experimented at length with all of the other standard blood stains, including Ehrlich's triple stain, the Jenner stain, Goldhorn's stain, Chenzinsky's, Romanowski's, the eosin and hematoxylon stain, etc., and have abandoned all of them for this method. I shall not enter into a description of the technic, for this may be found in the text-books mentioned above, or in Wright's original article.

The stain is a combination of eosin and polychrome methylene blue in solution in wood alcohol. It is essentially a micro-chemical re-agent which is composed of a basic (methylene blue) and an acid element (eosin), one or the other of which reacts with every one of the structures found in the blood. The methyl alcohol in which the re-agent is dissolved fixes the smear during the process of staining, thus doing away with one of the most laborious and uncertain factors necessary in the employment of the Ehrlich triple stain; viz., fixation by heat.

Since the employment of this stain my results have been much more certain and satisfactory. I have time and again made and stained a dozen or more smears by the Ehrlich method only to find that not a single one was satisfactory for the purpose of the examination; often the best smears would be ruined in staining and the satisfactory stains would be those which were poorly smeared.

In a properly stained specimen we find a most beautiful differentiation of the various leucocytes, the nuclei of which take the blue color, or some shade of it, the protoplasm at the same time taking up a modification of the blue or red according to the class to which it belongs. The blood plaques are stained a purple, the red blood corpuscles an old gold. Plasmodia malariæ stain a light blue; their nuclei red, which with the greenish appearance of the pigment granules, presents a very beautiful picture. The nuclei of the red blood corpuscles, if present, take up the methylene blue and are easily observed.

I shall not attempt in this paper to discuss all of the possible conditions in which variations from the normal are to be found in the stained blood smear. I have selected a few typical examples from my records showing the value of this method of investigation. In all of these cases the microscopic examination of the stained blood smear was of greatest value as a means of diagnosis, or as an indication directing subsequent examinations, which were themselves diagnostic. In some of these cases which I have briefly outlined the diagnosis was obtained immediately from examination of the stained smears.

Of course, in this locality by far the greatest field of usefulness of the blood stain is for the microscopical diagnosis of malaria through the recognition of the parasite in the peripheral blood or in blood taken from the spleen. For several years I used the fresh blood for this purpose, but have abandoned it now as a clinical method in favor of this stain. The only use that I make of the fresh blood is for the purpose of study of the living parasite and for occasional demonstration to classes in the hospital wards. I can say without hesitation that the parasite has been recognized by me very much oftener in the earlier stages of its development since I have been staining the smears. In a six months' service in four wards of the Charity Hospital assigned to Prof. J. T. Halsey, to whom I acted as Chief of Clinic, in a series of some fifty cases of suspected malaria, we never failed to find the parasites in a single case in which a diagnosis of malaria was verified by any other method. We never gave quinin without first finding parasites, and but twice did the patient ever have a paroxysm after admission; in both these cases the parasite was found on repetition of the blood examination. In several cases the patient was spared the ordeal of being unnecessarily cinchonized through the adoption of this rule. Not only did the routine examination of the blood for plasmodium malariæ enable us to know whether or not we were dealing with malaria, but it also enabled us to know particularly the type of the infection, which is vital to proper prognosis and therapeutics.

We can ascertain the existence of double infection and can know in advance whether we can expect the prompt disappearance of the parasite, as in a case of simple tertian infection after quinin in full doses, or whether it is to be a long fight, as in the case of æstivo-autumnal infection.

The identification of the kind of parasite and the knowledge of its stage of development enable us to get the maximum effect through our dosage of the specific remedy by giving it at the proper time. The number of parasites found is a good gauge, in my experience, of the severity of the infection. This alone would be a factor in deciding whether to give the quinin by needle or not.

I believe that in a great majority of cases the continued negative blood finding would eliminate malaria; however, many of these cases come to us for blood examination after having taken quinin, and, as is well known, the parasite is comparatively seldom found under these conditions. Recently, Krauss, in the *Journal of the American Medical Association,* October, 1904, has reported some 200 cases in which, following the idea suggested by some of the English clinicians, he carried on examination of the blood for the purpose of determining the influence of malarial infection upon the lymphocytes. His conclusions were that malarial infection was almost constantly accompanied by an increase in the percentage of the large lymphocytes over the small; the reverse is, of course, the case in normal adult blood. In utilizing this fact we must bear in mind that lymphatic diseases would alter the normal relation.

I have the records of a number of cases in which my results coincide with Krauss'. The following is one which is illustrative of the point: Case I. T., aged 23; initial fever of 18 days' duration; diagnosed by attending physician as typhoid; no Widal test made. Quinin given during third week in moderate doses with a rather constant reduction of temperature after administration of quinin. Temperature not over 99½ degrees during next six days. Then this rather sudden rise of temperature with considerable oscillation. Treated with quinin and pronounced by attending physician a recrudescence of typhoid. Temperature again went to normal at the end of 5 days, but after 3 days again rose; had quinin pretty constantly during these two febrile periods. At this time I was called in and made the following examination of the blood:

Widal reaction, negative; no plasmodium malariæ found; differential leucocyte count; polymorph, 26.5%; large lymphocytes 50%; small lymphocytes 20%; eosinophiles, 1%; basophiles, 5%; transitional, 2%.

After this examination, and in the absence of clinical signs of typhoid, I decided on giving quinin hypodermically, and prompt convalescence occurred. Three weeks later the differential leucocyte count was as follows: Polymorphs, 15%; small lymphocytes, 45%; large lymphocytes, 38%; eosinophiles, 2%. In this case the total lymphocyte count was as great as I have ever seen in an adult outside of lymphatic leukemia, but the actual leucocyte count of 6,800, made the next day after the first examination, enabled me to exclude this disease.

CASE II. T. R., male; aged 25. Continued evening temperature; malaise; slight jaundice; headaches continuing after free purgation with calomel. Had taken quinin in small doses when I first saw him. Blood examination showed no plasmodium malariæ, and differential leucocyte count was as follows: Polymorphs, 44%; small lymphocytes, 6%; large lymphocytes, 43%; eosinophiles, 2%. I gave quinin in large doses and patient promptly recovered. This case was examined before I began to use Wright's stain, and, although I have nothing excepting the prompt response to large doses of quinin upon which to base a positive diagnosis, still I believe the case was malaria.

CASE III. J. B., male; aged 38. Jan., 1905. Typical history tertian malaria; came from malarial district; during previous year had had three attacks of tertian malaria; in previous attacks took quinin sulphate by mouth in massive doses with little effect. Blood examination made January 3, 1905, showed no plasmodium malariæ. Differential leucocyte count as follows: Polymorphs, 61%; small lymphocytes, 17%; large lymphocytes, 17%; eosinophiles, 2%; transitional, 1%. Upon the differential leucocyte count and the very positive clinical history I based my diagnosis of malaria and at once gave bimuriate of quinin with urea by needle in 10 grain doses every morning for a week. There was no fever after the first day, and at the end of the week patient declared himself as feeling better than he had felt for a year.

I shall not take up your time citing cases where plasmodia were found. These are of very frequent occurrence, and among my records I have many which show an increase of the large lymphocytes over the small. However, I have also found a few in which such was not the case, and I believe more work must be done in this direction before we can consider this increase, as claimed by Krauss, diagnostic.

I cannot too strongly commend the routine examination of stained blood smears to those whose practice is in a malarial district. Not only do we get positive therapeutic indications, but we are enabled through the recognition of parasites in the blood to carry out prophylactic measures to protect those who are not themselves infected. With our present knowledge of the life history of the plasmodium malariæ, we are recreant to our duty if we subject a patient in our care, who is the host of the malaria plasmodium, to the bites of mosquitoes. In an up-to-date hospital every patient with these organisms in his blood should be kept either in a mosquito proof room or in a mosquito net until the parasites have disappeared from the blood. The scientific world today has reached the conclusion that could every case of malaria be screened or protected from the bites of mosquitoes, that malaria would disappear from the earth. This is, of course, impossible of accomplishment, but we know our ideal in this regard, and as physicians our duty is plain.

The following two cases show blood findings which are in themselves diagnostic.

CASE IV. A. M., male; aged 32; native of Italy. History of chill occurring at about the same hour each day for one month. Well and at work up to one month previous to admission. Red blood corpuscles, 768,000; hemoglobin, 10%; color index, 71%; white blood corpuscles, 7,000. Differential leucocyte count: polymorphs, 64%; small lymphocytes, 32%; large lymphocytes, 3.4%; eosinophiles, .4%; basophiles, .2%. During differential blood count of 500 corpuscles 21 normblasts and 51 megaloblasts were found, marked polychromatophilia and poikilocytosis. No plasmodium malariæ found in the blood in 30 examinations. Diagnosis of pernicious anemia in this case could have been made from the blood smear alone. Autopsy confirmed the diagnosis.

CASE V. W. H., aged 57, male. Patient referred to me for examination of the blood with the clinical diagnosis of malarial anemia. No plasmodium found in the blood. Red blood corpuscles, 712,000; H. b. 25%; color index, 1.78%; white blood corpuscles, 2,500. Examination of smear showed extreme poikilocytosis and polychromatophilia and a marked increase in the average size of the red blood cells, 275 megaloblasts per cu. mm. Differential leucocyte count: polymorphs, 51%; large lymphocytes, 5%; small lymphocytes, 43%; basophiles, 1%. Here examination of the smear was made first, and, as can readily be seen, was diagnostic.

Case VI. H. C., male, aged 62; clinical diagnosis malaria; referred to me for examination for plasmodium malariæ. In examining the smears an actual leucocytosis was found and an increase in the number of lymphocytes, as shown by the differential leucocyte count: Polymorphs, 9.5%; large lymphocytes, 67.78%; small lymphocytes, 21.83%; eosinophiles, 5%; myelocytes, .02%; basophiles, .02%. An actual count of leucocytes was made and 40,000 were found per cu. mm. At this time also the red blood corpuscles were 4,100,000 and the H. b. 68%. Here our examination of the blood smear suggested the necessity for making the actual counting, and the two together gave us an absolutely certain diagnosis of lymphatic leukemia.

Case VII. R. H., male, aged 35. Blood finding: Red blood corpuscles, 4,440,000; white blood corpuscles, 50,000; Polymorphs, 15%; large lymphocytes, 18%; small lymphocytes, 6%; myelocytes, 41%; eosinophiles, 20%; microblasts, many; normoblasts, many; megaloblasts, few. Feces examined for ova with negative results. The examination of smear from this case alone would be diagnostic of spleno-myelogenous leukemia, even in the absence of rather definite clinical symptoms.

Case VIII. Mrs. W. T. B., aged 42. Referred to me for persistent headache and indigestion of two years' duration. No lesions of the eye or in the nasopharynx. The following examination was made: Red blood corpuscles, 4,672,000; hemoglobin, 65%; color index, .79%; white blood corpuscles, 14,000. No plasmodium found; no variation in the size, shape or staining qualities of the red blood cell. Differential leucocyte count showed the following: Polymorphs, 51.3%; small lymphocytes, 16.6%; large lymphocytes, 5.6%; eosinophiles, 25.3%; transitional, .3%; basophiles, 6%. In this case the large percentage of eosinophiles found in the blood pointed towards intestinal parasytismus and suggested examination of the feces. This was done and the ova of uncinaria americana found.

This case is only one of many which have been reported in which intestinal or other gross animal parasite has made its presence known to the physician through its effect upon the leucocytes. We, of the South, cannot be too vigilant in our investigations along the line of this disease, and any method by which we can determine its existence is welcome. It is not the extreme cases of this disease coming from a region notoriously infected in which we need the aid of the microscope in diagnosis, but it is the mild types of infection of this sort in which we must call the microscope into use in order to make a diagnosis. Any case of mild or moderate severity is from the standpoint of public hygiene almost, if not quite, as much of a menace as one of the severer types.

In every one of these cases the most valuable element of the blood examination was the examination of the stained smear. I wish to emphasize the fact that this stain and examination of these smears is a procedure easy of accomplishment by the general practitioner, no matter where he is located, provided he has a microscope and a little knowledge of how to use the same.

There is no method of clinical diagnosis which gives better return in point of accuracy and information furnished in proportion to the time spent upon its acquisition than this one.

During the last year or two several of my professional friends living in the country have, in personal communications to me, reported their satisfactory experience in the application of this method of blood analysis. To those who have not a microscope at hand, blood smears made as I have indicated above can be sent to any laboratory and the examination made.

I have not attempted in this paper to announce any new discovery, but wish simply to endorse a technic which I have thoroughly tried, and to call the attention of the profession of the Southern States to this diagnostic measure which has proved so useful to me.

DR. J. R. FRIDGE read a paper on

Suppurative Otitis Media.

The middle ear has long been recognized as an exceedingly favorable site for the development of a suppurative condition, from the fact that we find here so much connective tissue, forming the framework of the vault which serves to support the ossicles in their positions.

A primary suppurative otitis media points to an infection of the vault, rather than to the cavity below. Any suppurative process of the tympanic cavity is a serious matter, involving, as it does, the delicate structures of the middle ear, and in many instances the life of the patient also. Acute otitis media is a very painful condition while the chronic forms are not at all so. If the condition is one of a few days or weeks, it is termed acute; one standing for a few months, or years, is termed chronic.

In my clinical work I have not, as yet, been able to draw that fine line of demarcation between the ending of the acute and the beginning of the chronic stage that some authorities do.

I have, therefore, included both of these under a common head, as I regard them as simply different stages of the same pathological process.

Suppurative otitis media has three well defined stages.

1. The stage of congestion, or that before the rupture of the drum membrane.

2. The stage after the membrane has given away, and during the period of discharge.

3. The dry stage which begins when the discharge has ceased. In the first of these mucous membranes are swollen, edematous and exudative, the exudation consisting of serum mixed with blood or later with pus, in varying proportions.

The deeper layers of the mucous membranes soon become affected and the pus becomes greater in amount and thicker in character. Pressure symptoms are early manifested, and pain is severe until the drum gives way and the discharge escapes through the external auditory canal, when much relief is experienced. One ear only is affected as a rule; though both are sometimes so; in the latter case the disease has usually followed some exanthematous condition. In those cases of recent origin not yet having assumed the characters of the dry, or third stage, the swelling is of a stagnated nature involving the blood vessels, an interstitial; serous or cellular infiltration confined principally to the sub-epithelial structures. The epithelial lining suffers more and more from day to day until lost in the suppurative process, when we find a soft, red or granular appearance, or large granulation tissue or polypi make their appearance as a result of hyper-plastic growth. In the second, or chronic stage, there may appear new connective tissue elements, resulting in adhesions or thickenings; calcification or atrophy may follow in the linings of the middle ear or tympanum. The osseous walls may suffer damage, a carious process setting up that is very rebellious to treatment.

Cholesteatomatous collections are frequently found in the attic and antrum. The labyrinth may suffer only from a transient hyperemia, or a destructive suppurative inflammation often leading to practical or complete deafness. It may be that from previous causes the tympanic membrane has been thickened and toughened, and it may refuse to yield to a suppurative process behind it.

If this should be so, the pus must take its escape either through the pharyngeal end of the eustachian tube, or through the cortical substance of the mastoid cells behind the ear.

Otitis media may be excited by a variety of different things; some of these are scarlet fever, measles, diphtheria, naso-pharyngitis extending out through the eustachian tube; the nasal douche improperly used, attempts at removal of foreign bodies by unskilled hands, and dirty instruments. An instance of the latter is now under my observation where a woman, feeling some uneasiness in her ear, drew from her hair an ordinary hair-pin, and with the bent end began digging down in her ear for a supposed foreign body; within forty-eight hours she developed a severe case of otitis media, external and internal, from which she has suffered much. Hair-pins are very dirty, and being full or covered with germs at all times, are very dangerous if used in this way; they break or bruise the delicate coverings, and at the same moment deposit their infecting cocci, and the case is on without delay.

Influenza or la grippe seems to be the source of many cases of suppuration of the middle ear. Some authorities claim that infections due to epidemic influenza are specially liable to set up inflammation of the mastoid cells. Malarial infection, tuberculosis, and especially the laryngeal form, pneumonia, typhoid fever, all play their part under favorable conditions in producing middle ear troubles. One thing, it seems to me, has caused more trouble with the middle ear than all others combined, and still this cause seems to be so often overlooked by those of us who are not working specially in this field, and that is causes in the nose and naso-pharynx; conditions that render these surfaces unhealthy; blocking up the secretions here and carrying infection to the middle ear through the eustachian tube. Bad or imperfect drainage of the nasal tracts of the naso-pharynx and the eustachian tube explains the cause of most suppurative conditions of the middle ear. Many of the defective drainage cases will continue for years; despite all other forms of treatment except that which re-establishes the drainage system. Secretions that are held in the antrum, mastoid cells or tympanic cavity, and especially the vault or attic, will prolong these cases indefinitely. The closure of the pharyngeal end of the tube from mechanical causes and the location and small size of the opening in the drum membrane simply bottles up, as it were, these decomposing substances, only a portion of them escaping at a time. I well remember having witnessed, while doing clinical work in New York a year or so ago, a post-mortem in which the middle ear had become so altered from prolonged suppurations that adhesions had set up dividing the middle ear into some half a dozen compartments, each cell or division being filled with pus.

The possibility of a condition of this kind should not be overlooked in those prolonged cases that prove so rebellious to treatment. The osseous walls or ossicles themselves may become carious or necrotic, and prolong the case indefinitely. Taking these chronic cases as a whole there is one reason more than any other that is responsible for their chronicity, namely, neglect of proper treatment of the nasal and naso-pharyngeal spaces, removal of adenoids and exostosis, etc.

These chronic conditions are usually painless, and the seat of the disease being hidden away out of sight are often allowed to go their way for long periods of time without any attempt at curing them. I believe that this painless condition is unfortunate for the patient, for were it otherwise, assistance would be sought and a cure perfected in many cases before irreparable damage had been done to the very delicate structures contained within the middle ear. Could the patient see the diseased area they would seek skilled treatment earlier than they do. Note how quick people seek treatment for skin troubles or any external conditions that are exposed to view. Couple these facts with the advice so often given these cases by the laity; namely, "let it alone," and it partially explains the negligence shown in these cases.

This state of affairs as regards pain is radically changed in the acute or first stage of these troubles, a sense of pressure, heat and fullness, with acute pain, is noted in the ear and over the side of the head, being generally worse at night, following the line of other diseases which seem to punish their victims more at night than in daytime. This pain and general discomfort grows more and more intense until the secretions make their escape, when much relief is felt by the patient. In some cases there is a persistent pain even after the drum ruptures, and here it is well to consider the possibility of the extension of the inflammatory process to the venous sinuses, dura mater or brain.

Various subjective sounds are complained of in the acute stage, but disappear when suppuration occurs and the drum gives away to reappear sometime later in the third or dry stage.

Rarefaction of air cannot occur in the tympanic cavity if there be a perforation in the membrane tympani. The noises are very annoying in some old non-suppurative conditions, the drum is retracted, making pressure on the stapes, which seems to be the cause of these subjective sounds. In exudative conditions the hearing is much reduced and in labyrinthine involvement total deafness may be present. It is largely believed that a perforation in the drum will lower the hearing to a greater or less extent, but I do not take part in this belief to any great extent from the fact that in some instances we see a drum almost entirely destroyed and still very good sense of hearing retained; hence we must look elsewhere for the causes of hard hearing in such cases. I think it is due to the thickening of the ossicular membranes or inspissated secretions upon these structures, thus interfering with the immobility of the stapes in its fenestra, or doubtless involving the delicate labyrinthine structures. In the third stage the membrana tympani may be entirely destroyed, and a fair degree of hearing retained. Again I have witnessed the healing of the perforation without any improvement in the hearing. It is frequently noted that where one ear becomes deaf from purulent otitis media, the other ear seems to take on an atrophic condition. Children often suffer from an acute otitis media without exciting suspicion until a discharge appears from the external meatus. In most of the cases the child is fretful, throws its hands frequently to its head in an indefinite way and exhibits more or less nervous manifestations. In more severe cases there may be convulsions or coma. Physicians, as a rule, in general practice, do not attach sufficient importance to suppurative conditions of the middle ear, the greater number of them not even possessing an ear speculum, or a head mirror, and in this way frequently overlook impending suppurative conditions here, and especially so if the ear becomes infected in connection with any exanthematous conditions. In such cases, though pain may be complained of in the ear, or side of the head, it is often confounded with the general condition. Otitis media may closely simulate in the acute stage a meningitis and may be mistaken for it. A beginning otitis media may extend through the petrosquamous tissue and set up an active inflammation of the cerebral meninges. Should the ear be carefully examined with a speculum and good head light the condition can usually be made out fairly well. Suppuration of the middle ear is also becoming a business affair. Life insurance companies are beginning to ask what effect these conditions are having upon the duration of life. We are not very well informed on this most interesting subject now. The profession is, however, giving the matter more and more attention and even the laity are beginning to attach more importance to it than ever before. We hope, therefore, to be in a position soon to answer this question with some degree of satisfaction to ourselves as well as to others. Many good authorities assert today that patients who suffer from otorrhea do not enjoy the average duration of life. They frequently fall victims to consequences of the disease direct or to secondary troubles which might otherwise have been escaped. Von Froltsch maintained that chronic purulent otitis media is equally as serious a condition as valvular disease of the heart or hernia. I do not take this extreme view of the matter, cannot agree that it is as bad as organic heart trouble, but nevertheless I do claim that applicants for life insurance who suffer from chronic otorrhea should be considered very seriously. They are not first-class risks and must be classed amongst those whose lives are held to be sub-standard and require additional or higher premiums. The source and character of this discharge should be looked into and if we find a small perforation in the drum, and that the attic or antrum mastoidum or mastoid cells be affected, the danger must be recognized as much greater than otherwise. The anatomical formation of the parts make the complete removal of the discharges very difficult. The consequent stagnation of the purulent products form a constant menace to the life of the patient. If the discharge has an offensive odor and this persists in spite of frequent cleansings, we may reasonably suspect caries of the osseous structures as the cause of the persistent discharge. In children with large opening in the drum and stringy tenacious discharges, you will generally find that adenoids are responsible for the discharges.

TREATMENT.

The intensity of the subjective symptoms and severity of the attack will have their influence in the manner of treatment to be adopted. In robust patients, otherwise healthy, if the pain in the acute stage is severe, the local abstraction of blood is of much service and especially so if it is followed immediately by warm applications. These fullblooded patients will take two to four leeches divided between the tragus and the mastoid process. In children one or two leeches over the tragus is usually sufficient. In the absence of the natural, an artificial leech may be used with satisfaction. Mild cases do not call for blood letting, warm applications affording relief; as a rule, I do not like ice in these cases as it seems to mask the symptoms, and often throws one off his guard; the case frequently appearing improved in twenty-four to thirty-six hours, only to turn up again later. I have had some results from irrigating the external canal in the acute stage with sterile warm water throwing a continuous stream from a fountain syringe as hot as can be borne for twenty-five or thirty minutes at a time. Hot applications should not be used continuously for more than twenty-four to forty-eight hours unless you get as a result a boggy condition of the tissues, which is not desirable. Always stop them as soon as pain is relieved. Medicinal applications have not done much in the way of giving relief in these acute cases for me. I have tried almost everything, but have found them mostly inert locally applied. Tinct. opii and belladonna have seemed to afford some relief in some cases, and absolutely none in others. Cocain, so valuable in so many other conditions, is a failure here, doubtless because it is not absorbed. I have got better results from 12% sol. of carbolic acid in glycerin as an ear drop than anything I have ever used. I usually order a drachm of the acid in sufficient glycerin to make one ounce, and drop this into the external ear. It sterilizes the surfaces and the hygroscopic nature of the glycerin evidently promotes the anesthetic effect of the acid and glycerin mixture.

Menthol, gr. x; chloroform, min. v; olive, ℥iv, makes another very good mixture in these cases. When the pain will not yield to these lighter measures, I give an opiate, perfectly morphin sulphate hypodermatically, in sufficient dose to give temporary relief.

I do not like much opium for the same reason that I do not like ice in these cases. Watch the drum membrane closely for tension and evidence of exudation, and just as soon as any decided bulging can be made out, do a paracentesis at once. Do not do this operation carelessly or lightly, it is an important procedure and should be done under great care. Make a free incision, beginning at the upper edge of the bulging and pass through all the way down, giving free exit to any secretions that may be held in the tympanic cavity. The walls of the tympanic cavity are in the immediate vicinity of important structures, and pressure within the cavity should be promptly relieved. Incision at the proper time lessens the danger from pressure of infecting the mastoid cells, relieves the pain and saves the tympanic membrane from greater damage later on when spontaneous rupture would take place. Early incision and thorough drainage would many times save the mastoid cells from infection later on. The second stage or stage of suppuration is entirely different from the first or the acute stage. In the second stage we seldom have any pain, and it too often happens that when the pain in the acute stage has ceased, the patient thinks he will soon be well and relaxes his efforts at cleanliness, the drainage being often imperfect, a portion of the secretions being always held in the tympanic cavity, the case soon assumes the chronic forms, and if left alone may continue to run or discharge for years to come. I am now treating a case of a young man, aged twenty-four years, who is liberally educated in a general way, is in good, healthy financial condition, well able to pay for treatment, who has been suffering from chronic suppurative otitis media since he was three years old. At that age he suffered from an attack of measles and for all these years he has had no intelligent systematic treatment at all. His hearing is very bad now, and the result of treatment is uncertain. In these suppurative conditions, drainage is our chief reliance; without it we cannot cure these cases, with it thoroughly established, we can cure nearly every one of them in so far as the discharge is concerned.

Dr. J. G. Huizinger, of Grand Rapids, Mich., published an article in *American Medicine,* October 1, 1904, on the subject of treatment of chronic suppurative otitis media that is the clearest cut expression on the subject that it has been my pleasure to read. He lays great stress upon the subject of proper drainage in these cases. He claims that we must establish and maintain thorough drainage if we hope to handle these cases with success. He presents three schematic drawings to more connectedly convey his ideas on the subject, one showing the middle ear and the tubes connected with it, as they should be in health; a second one showing a constriction at the pharyngeal end of the tube, and an intact membrane tympani, thus forcing the secretions into the mastoid cells; and a third one showing the same condition as the second, except that the drum has given away and the contained pus is being discharged through the perforation.

The drainage from the middle ear tends to find exit through the pharyngeal end of the tube by force of gravitation, as the external end of the tube is on a higher level. Anything therefore that tends to stop up the pharyngeal end of the tube at once obstructs drainage and sets up mischief in the tube and tympanic cavity. Mastoiditis would almost certainly follow in all cases of acute suppurative otitis media, were it not that the drum gives away in most cases before the cells become infected. In doing a paracentesis don't take a straight knife and simply stab the drum tube, but use a curved one and remember to go high up and cut through to the bottom. If no pus is formed the bleeding that follows affords relief and often cuts short an otherwise impending suppuration. In those cases where the drum has ruptured spontaneously it will be often found that the opening is too high or too small to establish perfect drainage and these cases should be freely incised to let out any reserved secretions that are being held there. After opening the drum, see that the eustachian tube is also open so that you may be sure of drainage both ways.

This condition must be maintained throughout the period of discharge. Failure to maintain this open system will result in failure to cure the patient. The best method that I have tried to open up and keep open the eustachian tube is the eustachian catheter. This instrument is introduced through the nasal cavity, the tip of the instrument engaged into the pharyngeal end of the eustachian and a Dench inflammation outfit attached and several short and vigorous inflations made on the bulb; this will force air through the tube and out the perforation in the drum membrane, thus actually blowing the secretions lying along the tube out through the external auditory canal. I generally use some medicated vapors in the cup of the inflating outfit. A solution of camphor and menthol is good. If the tube is tight I remove the inflating tube from the proximal end of the catheter and with an ordinary medicine dropper I insert into the catheter a drop or two of adnephrin, 1 to 1000, or solution of adrenalin chloride, 1/1000; possibly a drop of 4% sol. cocain may also be inserted in the catheter. I now replace the inflating tube and blow this solution in the eustachian tube. It acts like magic in some cases, contracting the swollen linings of the tract and you immediately get volumes of air through the tube where a moment before you could get none. This being done I puff air vigorously and blow out the retained secretions. I now lay my patient down, diseased ear up, and insert some cleansing solution in the external auditory canal; place my thumb over the tragus and make firm, deep pressure and in this way run my antiseptic solution all the way through the tube and out into the pharynx. In some cases old strictures of the tube will be encountered and no air can be forced through. Now resort must be made to the bougie. The catheter being introduced as before, the bougie is insinuated along the cavity of this, until it engages in the pharyngeal end of the tube. Great care must be exercised in sending the tip of the bougie forward to not bruise the mucous linings. If the latter should occur, you complicate matters very much by opening up new avenues for further infection and besides the seat of puncture swells and thus even more effectively than before shuts off drainage. With due care this should not occur. Gently twist and change the position of the bougie, making gentle pressure all the time until you have reached, if possible, the tympanic cavity. Now let your instrument remain in situation for ten or fifteen minutes. Do this every day, gradually increasing the size of the bougie until a No. 5 or 6 can be inserted. Some authorities use gold bougies and the galvanic current to open up these strictures, but I have succeeded just as well, and I sometimes think better, with the ordinary silk or whalebone bougie as with the current. In experienced hands the bougie is a valuable aid, in these cases results being very satisfactory.

I am in the habit, where the perforation of the membrane is small and seems disposed to heal before the process of suppuration is stopped, of destroying the drum outright with chromic acid fused on the tip of a probe. This will immensely increase your drainage system and add much to your chances of a cure. When the outlets are well opened up we have met the first and most direct indications of treatment. Now I use a small middle ear syringe and with some antiseptic or germicidal solution, bichloride 1/2000 being one of the best, I syringe out the attic well, driving the solution through the whole tube if I can. I am particularly fond of a solution of bi-chloride of mercury in dioxogen. If used in this way the dioxogen carries the mercury to every portion of the diseased cavity and tube. The mercury being a powerful germicide greatly lessens the dangers of infecting new areas by the evolution of gas from the dioxogen. Any method adopted must be carried out systematically or your results will be disappointing both to yourself and your patient. Remove polypi and exuberant granulation. Never plug the external auditory canal with cotton or any other substance, but leave it open to facilitate discharge as much as possible.

In children under twelve years always look out for the adenoids, and if found curette them away most thoroughly. These enlarged pharyngeal tonsils often close up the pharyngeal end of the tube and in many such cases simple removal of the adenoid growth will cure your suppurative middle ear trouble. In adults more especially, never forget the nose; the otologist must also be rhinologist. In this connection I will briefly recite a case in point: A young man, age twenty-seven, the son of a druggist, came to me last November with a history of a running ear for over twelve years. Various attempts had been made to cure the condition by his family physician, without success. Upon examination of the nose I found a large septal spur corresponding to the side of the discharging ear. I promptly sawed this away under cocain anesthesia and the ear got well almost before the seat of the operation had had time to heal, and remains well up to this writing, May 1, 1905. His hearing was very bad at the time of his operation and this has since improved very much. I mentioned above an article of Dr. Huizinger and his closing remarks are so clear cut and well chosen and meet my ideas so well on preventive treatment that I cannot do better in closing this article than to do so in his words. The doctor states: "Much has been said upon this important subject, but the fact that the profession as a whole is still to a lamentably large extent ignoring important and well known pathologic conditions of the nose and naso-pharynx, makes it necessary to continue discussing this subject until it receives such consideration as it merits. I believe that I am quite conservative when I state that from 60 to 75% of all cases of purulent otitis media are preventible. The following facts should be persistently and judiciously presented to our patients. Otitis media is almost invariably the result of diseased conditions of the nose and naso-pharynx caused by pathologic enlargement, malposition or deformity of certain structures or tissues whose cure in the majority of cases requires minor surgical intervention in addition to such local and constitutional treatment as may be indicated. Catarrh generally speaking is a curable condition and the only reason why so much skepticism is constantly manifested with regard to this treatment is because the profession has endeavored to cure it by means of simple medication alone, without reference to the deformations, malpositions and malformations that may exist within the nasal cavities. One of the great fundamental laws of therapeutics has been grossly ignored, viz.: that all anatomic malformations and displacements must be correct in so far as they interfere with the functions of any organ or part of the body. While simple medication alone often gives great relief, yet it rarely cures. The majority of cases require surgical treatment in order to obtain permanent results. Let catarrh receive proper recognition at the hands of the profession and the day of otitis media will largely pass into history. Remove the hypertrophied tonsil, curette the naso-pharynx for adenoids, straighten the nasal septum, cauterize or amputate such parts of the turbinals as are unduly enlarged and cause pressure symptoms, saw away spurs, ridges and bony projections and thus make the nasal cavities as nearly normal as possible. Indeed this is practical preventive medicine."

DISCUSSION.

DR. KING: I think that the doctor has covered the subject so thoroughly that there is very little to be said.

I wish to speak on the subject of *puncture* of the drum. We find very often on the part of parents opposition to having the drum punctured. There is an old idea that a puncture has a bad effect upon the hearing. Of course that is not the case. In these acute infections a puncture gives immediate relief to the drum. It is sometimes very hard to overcome this idea of the parents. You cannot keep a puncture open. It will heal up sometimes within forty-eight hours. I have had cases where I have removed a greater part of the drum and it actually re-formed within a very short time.

In cases where it is necessary to puncture the drum, and I cannot overcome the objection of the parents, I prefer not to treat them. When you undertake the treatment of a case, do the work thoroughly.

DR. DUPUY: It strikes me that a point of interest is the direct relationship between acute inflammation and the chronic suppurations. Experience supports the idea that neglected cases of otitis will eventually become chronic. The question then is a practical one. Who is to blame? The man who first sees the case. It is his duty to see that it receives attention. It is to be treated in the modern surgical aseptic way. The care of acute otitis is a point of supreme importance.

Dr. Homer Dupuy read a paper on:

Acute Affections of the Pharyngeal Tonsil in Early Life.

While the subject of hypertrophy of the pharyngeal tonsil has been well-nigh exhausted by voluminous contributions, one phase of the question has been completely ignored by the older observers, and is scarcely given its deserved attention by the present-day clinician. We are all familiar with the symptom complex of chronic enlargement of the tonsil, for many of us have come to regard it as a pathological condition originating rather abruptly instead of one resulting from acute inflammatory attacks. It is precisely the acute inflammations of the adenoid which constitute an interesting chapter in the diseases of children.

This lymphoid deposit appearing early in the intra-internal existence of man, at birth it is sufficiently developed in most subjects to render it a vulnerable area. Its histologic structure makes the adenoid an easy prey to microbian invasion, as it is essentially lymphatic tissue, which in itself, whenever disturbed, is to be regarded as an anatomical point of low resistence; this is particularly true in early life when this variety of tissue is so highly developed. In very young subjects this adenoid tissue is soft and pliable; the surfaces are lobulated, presenting distinct crypts; add to this an external vascularity with a preponderance of glandular elements, and we have present anatomical characteristics which render the naso-pharynx a suitable culture bed. This adenoid being the older tonsil in the history of animal life it is the first to become affected by pathological changes. The faucial tonsil begins its development later. This I know is not the current belief, the faucial tonsils having received the brunt of the blame for diseased conditions about the oral and naso-pharynx. Embryology and the study of a few hundred cases of adenoid affections in children, have, however, afforded me abundant proof that the pharyngeal tonsil, when acutely inflamed, is largely responsible for the so-called head cold in children.

For practical and clinical guidance the pathology of the pharyngeal tonsil is exactly that of the faucial. The morbid alterations which occur in acute inflammation of the latter, and which can be rightly interpreted even by the medical tyro, are repeated in every particular when the adenoid reacts to microbian invasion. The tendency of infant lymphoid tissue to take on inflammation explains why this tonsil is so frequently affected. After each attack there results a gradual increase of the glandular and connective tissue elements, which leads ultimately to a permanent enlargement. A vicious circle is thus established, as a chronic enlargement of the pharyngeal tonsil again invites recurrent attacks of inflammation. This is quite demonstrable in the adult when this organ persists, as in such subjects acute enlargement of the already hypertrophied tonsil is not uncommon. This is exactly what occurs in early life, for the proof of which we must have recourse to reasoning by analogy and to clinical evidence. It is now accepted that both in the faucial cavity and in the naso-pharynx the tonsilar inflammation is of infectious origin, the staphylococcus pyogenes being the organism chiefly concerned in the production of these affections. On the other hand, such dietetic influences as arise from the existence of lymphatism and uric acid, etc., must weaken local resistance, acting therefore as contributing factors. Gastro-intestinal disturbances are known to produce congestion of the whole upper respiratory tract, including the adenoid, which, under such irritation, becomes turgescent and is thus prepared to take on active pathological changes. Certain anatomical features in the architecture of the post-nasal space and the relation of the cavity to the nasal chambers and to the middle ear give us, when the adenoids are acutely inflamed, a clinical picture which, as seen quite frequently, is often misinterpreted. The inaccessibility of this region to ordinary examination, especially in the young subject, is one of the chief difficulties in arriving at a correct diagnosis. This explains why this affection is not more frequently recognized.

The symptom complex which presents itself in the cases which I have personally observed and which forms the basis of this contribution is quite typical; in fact, "He that runs may read."

M. D., white female, eighteen months old, while in apparent good health, contracts what is usually termed a head cold. Free nasal discharge. Mouth breathing at night. (Previous to this mouth always remained closed.) Extremely restless. Temperature varying from 100° to 101°. Examination discloses open and normal nasal cavities. Faucial tonsils are not visible. Pharynx healthy looking; when tongue is depressed, which causes gagging, a large quantity of muco-purulent secretion is squeezed from the naso-pharynx and passes down the pharyngeal wall. Lungs normal, no cough and not the slightest evidence of gastro intestinal trouble. Diagnosis: Acute pharyngeal tonsilitis. Treatment: Irrigation with a solution of glycothymolin and weak aqueous solution of peroxide of hydrogen. Irrigation carried on with a good spray, used through the nose. This procedure forces out large quantities of secretion from the naso-pharynx through the opposite nasal cavity. Ichthyol, in the form of an ointment, prescribed for home use. Castor oil, to rid the intestinal canal of the secretions, which quite naturally find their way into it. On the third day marked improvement in all the symptoms. Nasal breathing fully restored.

This picture, with slight individual variations, is duplicated every day in hundreds and thousands of instances. It is one of the commoner minor ailments of childhood, and is wrongly considered a head cold, if by that is meant an acute rhinitis, pure and simple. In fact, clinical experience has long since taught me that primary nasal affections are extremely infrequent at this period.

These active morbid changes in the nasal cavities generally mean that there is a pathologic progress going on in the post-nasal space. The clinical picture which I have outlined above offers variations according as the middle ear or the lower respiratory tract becomes involved. The eustachian tube being shorter and wider in the earliest years is an anatomical feature which in itself favors the passage of pathogenic organisms from the post-nasal space into the middle ear. It is therefore quite evident that an inflamed adenoid is a real menace to the ear. Deafness and otalgia occur quite frequently in such a condition. On the subsidence of the acute affection these phenomena disappear. The character of the adenoid inflammation, the virulency of the infection, will determine whether or not the disturbance culminates in an acute suppuration. By proper treatment, therefore, of the tonsilar affection we can oftentimes avert the extension of infection to the tympanic cavity and then diminish the possibilities of chronic suppurations which are now rightly considered to be the outcome of an acute otitis.

In many instances the secondary phenomena appear in the lower respiratory tract, where the effect is manifested either as spasmodic croup or a simple laryngitis, or as an acute bronchitis. These are some of the more frequent types observed.

While the clinical features of acute adenoiditis are quite distinct, and even typical, a smaller number of cases do not present clear cut symptoms pointing specifically to the naso-pharynx as the diseased focus. A septic temperature and general depression; the languid and irritable child, a short while since joyful and bright, are the outlines of a rather obscure picture of diseased action not accountable for in these particular instances by any lung or gastro-intestinal affection. Several noted pediatrists have only recently called our attention to the role played by the adenoid in just such a condition—when the head-symptoms lack prominence, for which we are apt to place the blame where it does not belong.

The causative relations of acute inflammatory affections of the pharyngeal tonsil to acute cervical adenoiditis is supported by uncontrovertible clinical evidence. I have observed this connection especially in the negro race.

Southworth in the *Journal of the American Medical Association* makes a notable contribution to the subject. Of paramount interest is the fact that when cervical gland inflammation accompanied the acute adenoiditis, in many of his cases suppuration of these lymphatic glands was prevented by active treatment directed to the naso-pharynx. We readily admit that the overlying integument may carry the infection to these glands, but there evidently exists another avenue of infection. It is a portal of entrance hitherto unsought for and yet one of great practical importance from the standpoint of prophylaxis.

The treatment which I have already outlined consists essentially in post-nasal irrigations with alkaline antiseptic solutions. At this early period we are compelled for evident reasons to reach the naso-pharynx by way of the nasal chambers—either a syringe or a good spray being used. I have a preference for the spray. With the child's head inclined forward, the danger of forcing septic material into the middle ear in my experience is very remote. Ichthyol ointment—say from 20 to 30 grs. to the ounce—is prescribed for home use. Its application in the nostrils guarantees that it will find its way to the inflamed adenoid.

Argyrol, 10 to 15%, in aqueous solution can be dropped into the anterior nares as the child's head is tilted backward. Its antiseptic and yet non-irritant properties have rendered me good services in post-nasal disinfection.

Appropriate systemic treatment is particularly addressed to any diathetic condition which might exist. Iodide of potash is undoubtedly effective in reducing acute lymphatic enlargements. Remember that the adenoid is a lymphatic. Chloride of potash, internally, watching its action on the kidneys, has its advocates, who declare it a specific. Several experiences have led me to believe that by treating the acute affection of the adenoid we prevent chronic enlargement. This, in itself, is no mean victory for a chronic hypertrophy, passes at once into the field of surgery.

CONCLUSIONS.

1. Head colds in early life are generally characterized by an acute inflammation of the pharyngeal tonsil—the nasal phenomena being purely secondary.
2. Apart from the many minor ailments caused by acute adenoiditis profound systemic disturbances sometimes follow.
3. The post-nasal tonsil being a terminal lymph node acts as an avenue of infection for the cervical lymphatic glands; treatment, therefore, of the tonsilar affection offers a very rational protective measure for the prevention of acute lymphadenitis in the region of the neck.
4. Early and active treatment of recurrent pharyngeal tonsilitis will sometimes prevent a chronic enlargement of this post-nasal lymphatic deposit.
5. Prophylaxis addressed to the upper air passages will consist essentially in nasal and post-nasal cleanliness, the ideal being attained when the child's nose and naso-pharynx will receive nearly the same attention we bestow on its teeth.

DISCUSSION.

DR. DOWLING: I want to thank the doctor for his excellent paper. I hope that it will have some influence with those general practitioners here, because they see these cases early in the treatment. They can send them to the specialist. I have a case in view that I have had under occasional observation for the past five years. She has a growth that I have repeatedly advised them to have removed, and yet she goes on suffering, and the parents permit it, and the family physician, who is a most excellent doctor, says that he sees no reason for having the growth removed, because they did not do that sort of thing when he was a young man.

DR. GORDON KING read a paper on:

Some Reflex Neuroses of Nasal Origin.

The study of rhinology offers no chapter more interesting than that relating to nasal diseases as a causal factor in functional disorders of the nervous system, nor can the student of neurology find a more fruitful field for observation and research than this subject presents. The role played by the nose in the production and manifestation of various so-called "reflex neuroses" has for many years been the subject of diverse and eloquent argument, and the pendulum of popular opinion has swung back and forth several times as experiments and investigations were carried out and results reported pro and con.

At the present day we may perhaps be inclined to accuse too many general conditions of originating in the nose, and the ever-ready cautery and nasal saw have come to play a very important part in the daily work of the well-meaning, but over-enthusiastic rhinologist who thinks to have found within the nose the mainspring of perfect health. Let us not, however, condemn too hastily nor take an extremely opposite view, for in late years progress has been made in rhinology as well as in other branches of medicine, and much of it is due to the perseverance and searching investigations of the enthusiasts. It is not my intention to extol the virtues of either the hyper-enthusiast or the skeptic, but to condemn the extremist of either sort while gaining from both those proven facts which may make the happy medium.

The subject of nasal reflex neuroses is by no means a new one, for many sensory, motor and vaso-motor phenomena in neighboring and distant parts were attributed even in ancient times to diseased conditions in the nose. The historical researches of John N. Mackenzie and Jonathan Wright have brought out some highly interesting facts along these lines from the works of the early writers. Many of their theories were, of course, absurd and mystical in the light of pathology and physiology of our modern school, and yet we have a great deal to learn concerning the true nature of these reflex neuroses.

For the production of a reflex act there must be brought into play an afferent sensory nerve, an efferent nerve, and between them a nerve center. The nose, with its highly sensitive mucous membrane receiving nerve supply from the olfactory, the trigeminus, the spheno-palatine and otic ganglia, and being connected with the gasserian and cervical sympathetic, besides having a rich vascular and lymphatic structure, would seem to be especially favored as the point of origin of reflex impressions. The important relation of the nose to the lower respiratory tract is well known, as is also its anatomical and nerve connection with the alimentary organs, and further, as pointed out by Mackenzie and others, it has a peculiar relation to the sexual apparatus.

Its blood and lymphatic supply is intimately associated with that of the cranial cavity and brain, which, aside from the question of nervous reflex action, may account for certain pathologic phenomena, such as aprosexia and epilepsy, both of which are attributes at times to nasal abnormalities. With these facts in mind it is not astonishing, therefore, that medical literature is full of reports of cases of all kinds of nervous phenomena traceable to nasal origin. It is not within the scope of this paper to review this subject in all its details, and my chief excuse for selecting it is to record some personal observations and to solicit your interest in this fruitful line of investigation, both in regard to local and general nervous manifestations.

A very common clinical type of this class of cases is the habitual "sniffles" of children. In this the child is constantly and often unconsciously twitching the end of the nose and the upper lip at irregular intervals during the waking hours, or is given to making a snuffling noise by sudden jerky inspirations or expirations of air through the nose. This is never to be considered as purely a habit without a material cause any more than mouth-breathing in children, and I have never failed in such cases to find some enlargement of the inferior turbinates or post-nasal adenoid hypertrophy as the fundamental cause. The habit quickly disappears when these abnormalities are corrected, which is sufficient proof of their causal relation. This phenomenon can be classed with those of the respiratory apparatus of which there are several forms, among others the reflex nervous cough, often attributable to the presence of enlarged turbinates, septal spurs, ridges or deviations, polypi and adenoid vegetations. In many cases the cough is due to the mouth-breathing incident to the nasal obstruction, and is not a true reflex. This can be usually determined by probing the suspected areas in the nose to excite the cough, or by the application of cocain to temporarily arrest it. In this connection must be mentioned the sneezing reflex excited by some form of intra-nasal irritation or hyperæsthesia, usually in the upper region of the septum and turbinates, and while this may be due to the introduction of irritants from the outside, as the pollen of plants in hay fever, or the inhalation of dust and irritant gases, frequently enough some abnormality in the nose is responsible for the trouble, and its removal affords relief. Nasal polypi and turbinal hypertrophy are chiefly accused of causing this condition.

Hiccough of frequent occurrence or intractable paroxysms has been found to originate in some intra-nasal irritation, a fact recognized in ancient times, and for which the remedy suggested was to press upon the inner canthus of the eye, or excite sneezing by tickling the mucous membrane of the nose. Thus one reflex was used as a remedy for another.

Common among the neuroses due to nasal stenosis we find laryngismus and spasmodic croup in children. Adenoid growth is usually to be held responsible for this, and here again the mouth-breathing is perhaps the exciting cause of the irritation in the larynx which results in the spasmodic closure of the glottis, and it is therefore not always to be considered a nasal reflex manifestation.

Next let us consider a condition, the pathology of which has always been a favorite subject of discussion, and one with which the general practitioner is in daily and strenuous conflict. I refer to asthma, and especially to asthma in relation to its nasal origin and treatment.

I confess that it was chiefly for the discussion of this disease that I felt induced to bring up this subject.

The recent writings of Greville MacDonald, the exhaustive and convincing researches of Alexander Francis, and the interesting experiments of Lazarus have done much to strengthen the belief already entertained in a vague sort of way that the nose is more often responsible for asthma than even the average rhinologist is inclined to admit.

Lazarus has thrown some light on the pathology of the disease by demonstrating that electrical stimulation of the nasal mucosa produced contraction of the bronchial muscles, and that this contraction ceased upon section of the vagus. It is now generally accepted that all cases of asthma are spasmodic, and that the contraction of the bronchial tubes is brought about by an unstable condition of the respiratory center, with some peripheral sensory disturbance as the exciting cause. Francis, whose remarkable personal observations comprise a series of 402 cases, holds to this theory, and further believes that the neurosis is always of reflex origin, and that the nose is the usual starting point of the afferent impulse. The experiments of Brodie and Dixon would appear to confirm this theory. In seeking to induce asthmatic contraction of the bronchial tubes by stimulation of various nerves, they never succeeded by excitation of any cutaneous sensory nerve, the stomach, intestines or cornea, and arrived at the conclusion that the best area for producing the reflex constriction is the upper and posterior part of the nasal septum.

Francis obtained a cure in a vast majority of his long series of cases by treatment founded on this belief, and has shown that nasal treatment has been effective even when no nasal lesion was apparent.

Contrary to the generally accepted opinion, he holds to the view that the presence of nasal polypi, septal irregularity, turbinal enlargement, or other apparent abnormality is not essential for the production of the necessary reflex excitation, and that where nasal lesions exist, and especially nasal polypi, it does not suffice in the treatment to correct these abnormalities. His treatment consists not only in removing any such lesion, but in all cases of applying the galvano-cautery to the upper portion of the septum to diminish the sensory excitability of the nerve endings in that region. In addition he gives due attention to hygienic and other measures calculated to improve the general nervous stability of the patient.

While this free use of the cautery smacks of empiricism, yet the harmlessness of the procedure and the results obtained thereby would seem to fully justify the adoption of this measure in every case, even if only in a tentative way.

I have recently had two cases where no nasal lesion was to be demonstrated except a slight puffiness of the mucous membrane on the upper part of the septum anteriorly. In one case, that of a medical student who began about two years previously to suffer with frequent attacks of asthma, associated with sneezing, one application of the cautery to the upper part of the septum gave immediate and, thus far, lasting relief. The remedy was so simple and the effect so satisfactory that I did not hesitate to try it on a second case that came under my care a short time since. In this case the nature of the asthma seemed to be bronchitic, and the nasal cavities showed nothing abnormal. Cauterization of one side of the septum, in the manner described, gave a marked degree of relief to the severity of the attacks, and a second application to the other side of the septum caused a cessation of the asthmatic symptoms.

In two other cases there were obstructive lesions, a large septal ridge in a man 25 years of age, and multiple polypi in a woman of 38.

In the former case removal of the septal ridge gave the desired result and the cautery was not used. The woman is still under observation, and although somewhat relieved since the polypi were removed, is not yet well, and the cautery will be used with the hope of obtaining a complete cure. Still another case of nasal reflex asthma recently came under my observation in which a small polypoid growth, the size of a pea, was found on the anterior end of the middle turbinate. Irritation of this little growth provoked a cough, and increased the asthmatic symptoms, and its removal gave relief. This patient had been subject to asthma of distressing severity for six or eight months, and his occupation was seriously interfered with.

These few cases have inspired me to further research along these lines, which I trust my brother specialists will also find a source of interesting study.

Various other neuroses may be traced to some abnormality in the nose, producing local irritation or interfering with its respiratory or olfactory function, such as parosmia, chorea, nocturnal enuresis, heterophoria, glaucoma, epiphora, cardiac irregularities, dysmenorrhoea, stammering, and a host of other motor and sensory disturbances. Richardson has reported cases of asthma associated with antral empyema cured by draining the antrum. Sargent Snow believes that 80 per cent. of cases of tic douloureux arise from nasal or sinus abnormalities, and that migraine is nearly always of nasal origin. From my own experience I must confess to a less degree of enthusiasm in regard to such cases than this writer seems to feel.

Society Proceedings.

Orleans Parish Medical Society.

President, Dr. C. Jeff. Miller. *Secretary*, Dr. Amedee Granger
141 Elk Place, New Orleans.

In Charge of the Publication Committee, Dr. Amedee Granger, Chairman,
Drs. Geo. S. Bel and E. H. Walet.

INAUGURAL MEETING.

SATURDAY, JANUARY 13, 1906.

Dr. L. G. LeBeuf, the retiring President, read the following address:

Address of Retiring President.

As it is customary for the outgoing President to say a few words at the last meeting at which he is to preside, I will do so in a brief résumé of the work done this last year, and at the same time extend my sincere thanks to my fellow workers on the Board of Directors, the officers of the Society, to the chairmen and members of the different committees as well as to the general membership, for their hearty support during the year. If anything has been accomplished to the credit of the profession, if anything has been done to raise the profession's importance in the eye of the public and the surrounding communities, it is wholly due to the splendid and successful fight waged this summer on the broadest and newest scientific medical facts known. The members of the Society, and the profession of New Orleans generally, have given their united support to the great sanitary campaign and the favorable comments of the medical press all over the country have attested to this. You have been the pioneers in the evolution of the mosquito doctrine and have added no mean stone to the edifice raised at Havana by the Reed and Carroll commission. Some bacteriological work of no mean value has been done by various members of the Society, and even if it has not been crowned with success, it will mean something in the future when this subject is further looked into. Many circulars were sent to physicians in the city on the line of medical education. One of these circulars addressed to the physicians and trained nurses, with special instructions to nurses at the bedside of yellow fever patients, was sent to 7,000 persons. I saw it in the hand of a trained nurse at Port Gibson, Miss., and in New York at two hospitals.

We had the honor to receive Drs. Juan Guiteras and Rupert Boyce and to listen to their learned addresses at a special meeting of the society. We completed on June 24 the bond issue for the payment of our new domicile. The last bond was subscribed to and paid for by Dr. T. R. Rudolph. On May 1, when the first interest coupon was due, we paid in the Bank of Orleans the total of $254 to cover the entire issue, except interest on six bonds donated by Dr. Perkins and the Arrangement Committee. There is remaining still in bank $85 unpaid on this interest account, and I want to urge the members to go promptly to the bank and collect their interest.

The Board of Directors on July 18 redeemed twelve bonds, by drawing. These numbers were 45, 46, 88, 123, 148, 172, 208, 242, 245 and 250. One July 18 Dr. Wm. M. Perkins, Chairman of the Committee of Arrangements for the entertainment of the Louisiana State Medical Society, succeeded by strict economy and splendid management to have a surplus in hand, from the funds subscribed, so he, and the committee he represented, bought and donated to the Society six bonds for cancellation, viz.: numbers 161, 162, 163, 164, 165 and 166. Later in December, finding that he still had a balance in hand, he again presented the Society with two more bonds, numbers 68 and 69, which I herewith present canceled, making altogether eight bonds donated, a total of twenty bonds redeemed, $500 of debt removed altogether, the first year of the issue of the bonds. We now own our own building, which, with repairs, has cost us a little over $8,000, all the obligations paid except the 240 bonds, held by members of the Society for future redemption. On account of our advantageous location, within a block of the projected union railroad station, our domicile, now a little over a year after its purchase, has a market value of $15,000, and certainly a commercial or speculative value of $30,000 in the next two years, when all the improvements projected are completed. I hope that the sale of this building, already too small for the increased membership of the Society, will in a year or two allow us to redeem all the balance of our bonds and have a handsome sum with which to build a large and more suitable building than the one we now occupy.

The increased attendance at meetings, an average of seventeen over last year, also increased attendance in the library—the larger membership all prove to us that a greater interest is being manifested in medical work.

The scientific papers were of a higher grade and in spite of the disorganization due to yellow fever only two less than the highest number ever presented. I regret to say that we had only two cases presented, during the year, while only nine cases were reported. I want to suggest for the action of the future officers the adoption of the plan in vogue in Northern societies, specially the Academy of Medicine in New York. It allows the immediate presentation of cases right after the reading of minutes, etc., leaving the executive part of the program last. In that way it prevents the delay now so frequent and will allow us to begin at the most interesting part of the program and further still permits the strangers or visitors to leave before the business part of the program comes up, reading of delinquent names, etc., and allows a man to be certain that such and such part of the program will be taken up at a definite time.

I suggest the following order:

1. Reading of minutes.
2. Presentation of cases.

3. Reading of papers of the evening.
4. Presentation of specimens.
5. Exhibition of new instruments and apparatus.
6. Executive session or regular order of business, reading of communications, etc.

Regarding the matter of the contract with the Journal, allow me to suggest some arrangement by which the Secretary or Chairman of the Publication Committee will confer with the editor of the paper, so as to let the printers have the material early enough so as to allow each author of a paper a chance to edit or correct his own proof. This would save many mistakes and raise the standard of the work done. Direct, for instance, the Secretary to hand his material on the 10th and give the writer of the paper from the 15th to the 18th to correct his proof himself, also state the date by which an application for reprints can be made and the exact cost per page, and number of copies.

To facilitate the work of the Board, besides special meetings called *pro re nata,* we agreed to meet regularly on the second Tuesday of the month. The work of the Board was also greatly simplified and facilitated by subdividing it in three sub-committees:

First. An auditing committee to report quarterly on the books of the Treasurer.

Second. A finance committee to keep in touch with the income and the obligations of the Society.

Third. A house committee to have charge of the building property, the management of the janitor, etc.

I wish to specially commend the excellent work of our able Secretary and Treasurer, and in conclusion to attest to the faithful and efficient services of our Assistant Secretary, Mr. Geo. Augustin.

DR. C. JEFF MILLER, the incoming President, read the following address:

Address of Incoming President.

GENTLEMEN:—You have conferred upon me the honor and privilege of Presiding Officer of our Society for the ensuing year. In accepting the position, I undertake a task which has been admirably filled in succession by a number of men who seemed particularly fitted to serve the interests of this organization during the period they were occupants of the President's chair. The list contains names of men well known for their ability as organizers, some noted for the special gift of creating the social and friendly spirit so necessary in such a body, and others who became noted for their self-sacrifice and the tedious labor they gave towards elevating the Society to its present standard.

In organizing the Society and accomplishing what they have done, they have made my duties by no means lighter; in truth, the responsibilities have increased many fold and I appreciate fully the confidence you have shown in entrusting me with such an undertaking. I have endeavored to fix fully in my mind the various phases and obligations incident upon the position and will labor to the best of my ability to make the administration a creditable one.

Our organization has long since passed the phase of its development, however, when the President has all to do with its success. Since I have served it as Secretary in 1897-98, it has become a chartered institution, owner of its home and the possessor of all the rights and privileges that an active, expanding body should possess which is destined to play an all-important role in the future of this community. In this work it can do little without the aid of its individual units. The individual member has, relatively, as much to gain or lose as any officer and I hope his resolution to contribute to the proceedings of the year will be considered as binding upon him as the promise that I make to serve you to the best of my knowledge. My predecessors have wrought well in their efforts to lay the foundation of a fine, virile organization, whose future we can anticipate with confidence.

It is plainly indicated in the several volumes of Transactions what is expected of me. The first and foremost responsibility is the upbuilding of the library. This has been the special pride of every administration. Nothing will so effectually weld the profession together and prompt the conclusion that membership is not only a special privilege, but a necessity, than a modern complete file of current literature. In this age of rapid bookmaking, even a working library is prohibitive to a physician. This burden is to be borne by the Society and the hearty co-operation of every member is here solicited in the effort made for a complete reference library.

A personal invitation is here also extended to every member to contribute to the scientific proceedings. It has been a matter for comment here and in other cities that we are not contributing our share to the literature of the day. This is the more to be regretted since there is so much valuable laboratory and clinical investigation being done here. If every member does his duty, he will be heard on some subject during the year. If he is constrained for lack of space on the program, this will be settled, even though it be at the expense of a special meeting.

I have often wondered if we are not just a little too exclusive in our regular scientific programs; whether we have extended as freely as we should invitations to medical men of repute from other medical centers to join us in our discussions? This custom, so general in many cities, gives frequent opportunities for comparing and estimating methods, and, besides, it develops a social feature which is always pleasant. I hope we may have more of it here.

Of the many things that will come before us during the year, there is no need to speak. I only ask your counsel and assistance and with these I am not afraid that the results will be satisfactory.

In conclusion, I wish to thank the members for the expression of confidence reposed in me by electing me presiding officer. I am aware that you did not intend it as a recognition for any great services previously rendered. I interpret it as a reward to one who has always prized his membership in the Society, who has never failed in his loyalty and faith in its future and has contributed his mite whenever he could towards making the Society the mirror of the professional work done in this community.

The chair then asked Dr. LeBeuf to introduce LIEUTENANT-GOVERNOR JARED Y. SANDERS, the annual orator for 1906, who spoke as follows:

Annual Oration.

Accepting the kind invitation extended to me by your body, I am here tonight to say a few words to the Orleans Parish Medical Society.

There are subjects, of course, that would be of great interest to you—subjects along the line of your lives—subjects of scientific research and of theories reduced to dogmas; but on such subjects I have neither the inclination nor the capacity to discuss before a critical audience.

I am glad to be with you tonight. I know a great many charming men who are physicians. Some of my warmest personal friends in this and other parishes in Louisiana have the right to put the mystic letters "M. D." behind their names. Personally, socially, man to man, they are a clever and fine lot of fellows, and as such I like them; but I don't like them professionally.

Of course I realize that a doctor occupies very much the same position as the man who lives in Texas holds to a gun. The man in Texas may never need his gun but once in twenty years, but when he does need it he needs it devilish bad; and we ordinary mortals who know not the mystery of the mixture nor the physic in the pill, may go through life for twenty years and never need a doctor—but when we do, we need him bad.

I am, by no manner of means, a firm believer in the faith cure. Whilst I am of the opinion that many an ill that flesh is supposed to be heir to comes from the mind and not from the body, yet I was never more thoroughly convinced that aches and pains were not altogether imaginary until I in recent years made the personal acquaintance of a large and influential carbuncle. This convinced me beyond all peradventure of a doubt that there were certain sensations of the body over which the mind refused to take jurisdiction.

We laymen may, in our days of buoyancy, youth and robust health, scout the idea of calling to our assistance the learned men of your profession, but all of these proud and vainglorious ideas are dissipated at once by the first twinge of pain. And even those who profess to have the least faith in the medical profession feel a sense of security and a restfulness when the doctor comes to the bedside. It may be true, as charged by many, that he knows nothing about what is going on in our "inards." It may be that he is merely guessing at the seat of pain. It may be that he loads the bottle with fine shot in the form of many medicines hoping that the charge will scatter in the taking; that some one drop will reach the right spot; but even if all these things be true, yet he approaches the sick bed with such an air of confidence in his own ability, with a manner that says at once to suffering patient and anxious family, "Be troubled not, I am here, pain and death must make way for me;" he feels your pulse with such a look of wisdom; inspects your tongue as if the fate of the world hung thereon; thumps your chest and back with such confident power; inserts between your lips the cold, calculating thermometer with such an air of finality that, perforce, before these many operations are over, the mind cure has got in its work and the medical profession receives its greatest endorsement at the hands of faith.

Of course, many men of many minds are necessary for the make-up of this work-a-day world of ours. That reasonable men do embrace the medical profession by preference is something we must all admit because we see living exemplifications of this fact on every hand. Why they should, has ever been a mystery to me. Of all the walks of life this thing of probing about in the innermost recesses of the human body; this thing of cutting off a leg here or an arm there with an equal degree of enjoyment; this thing of ever contemplating pain and suffering has, frankly, never been attractive to me; but it is done, and done by the brainiest, the brightest minds of the world. Men devote their time, their talent and their very life to the study of how to free the human race from pain and from death. In my humble estimation the heroes of the world are not the men who with shot and shell confront each other in death grapple on sea and land. Theirs is not the courage that appeals to me as of the loftiest kind. To shoulder a gun in defense of home and country is that which every man should do, and that which every *man* does do when occasion demands. The battle cry is as old as the world itself. Since the earliest dawn of history men of all nations and all climes have met and met and met again in the death grapple upon a thousand battlefields. This courage is the animal courage that is common alike to all the people of the earth; but I have always thought that the world hero was the man who gave up life that mankind might be bettered. The mad courage of the battlefield compares in not a thousandth degree with the cool courage with which gentlemen of your profession have faced death the world over. Calmly, confidently, have they gone around the stricken portions of the earth, alleviating suffering, studying disease, and laying down their lives that science in the end might triumph. The history of the betterment of the condition of mankind is a history of the march and triumph of your profession.

Men in the past have deserted their posts of duty and fled before the enemy; but whenever death stalks abroad in the land, no matter in which hideous form, there the physicians rally, face him, rout him. Of all the professions medicine stands pre-eminent, in that it ministers solely to those who are afflicted; in that its members approach the subject of life and death from the broad standpoint of humanity; in that, never content with the present, their eyes are ever fixed upon the future, working and striving for the benefit of suffering humanity.

Each of us in our sphere has duties to perform. Each of us in our walk of life must see to it that the community is protected. Upon no shoulder does this burden fall with greater weight than upon that of the gentlemen of your profession. In this city of ours a great and solemn duty confronts you. You are, in a great measure, responsible for the health and well being of this great city and State. We laymen must get our inspiration, our ideas, from you. You must see to it that this city is placed in perfect sanitary condition; must see to it that the health of the South, as far as it lies in your power and in your hands, shall be preserved. It is not for you or for me to say that because we are not upon the Boards of Health that the question of the public health concerns us not. New Orleans has just gone through a tremendous crisis in her development. We are the gateway of the great Mississippi Valley. The magnificent domain to the south of us should do their trading through this port, and we must so act and so conduct ourselves that no suspicion can possibly attach to our State and city, our people or our motives.

Gentlemen of the medical profession, you must lead this people in the right path; you must show it how to take care of itself; you must see to it that what ought to be done is done, and that what ought to be left undone is left undone; you must see to it that neither our officials or our people commit sins of omission or of commission; you must see to it that the health of this country is guarded as a priceless jewel; and you must see to it, no matter what comes, that the truth, the whole truth and nothing but the truth must be given to the world. Nothing will ever be gained by a course of secrecy. I am of the opinion that the only cases of disease that are dangerous are the cases that are concealed. If they are known, then their power for evil is gone.

MEETING OF JANUARY 27, 1906.

DR. R. M. VAN WART presented:

A Case of Probable Syphilitic Disease of the Meninges of the Lumbar Portion of the Spinal Cord.

The case was of interest from the standpoint of both diagnosis and treatment.

The patient, a white male, *aet* 46, single, laborer, was admitted to the clinic of the Touro Infirmary November 18, 1905, complaining of weakness and pain in both legs and some trouble in passing his urine. There was nothing of interest in his family history.

He was born in Germany and had lived in the United States since 1872. He had had malaria and smallpox. Five years ago he had what he calls rheumatism in his back which disappeared in a few days. Two years ago he took treatment for about a month. There were no secondary symptoms. He used alcohol occasionally. His occupation has always led to great exposure.

He dated the onset of his present illness from a strain to his back received while carrying a tie five months previously. This at first caused pain in his left shoulder which later became localized in the lumbar spine. He was obliged to stop work. Ten weeks later on attempting to resume work he injured his ankle owing to awkward movements due to the weakness in his left leg. This again caused him to cease work and he has not been able to resume. He complained chiefly of weakness and pain in the left leg. The pain is chiefly in the front and inner side of the thigh. It is more or less constantly present and is worse when he tries to walk. There is also pain and stiffness in his back. He has trouble in starting the urinary flow, but when once started there is no further difficulty. There is some weakness in the right leg manifested chiefly by a tendency for the knee to give way. His bowels are constipated. His appetite is poor. He sleeps poorly. There are no symptoms referable to the other organs.

The examination of the various organs was negative. There is a well marked scar on the penis. His gait is stiff and he drags the left as he walks tending to protect it as much as possible. The back shows rigidity of the erector spinal muscles and great limitation of movement in all directions in the lumbar region associated with considerable pain. There is very marked atrophy of the muscles of the left gluteal region, thigh and leg, the circumference of the thigh being eight inches and that of the calf six inches less than on the right side. The muscles are soft and flabby. There is also to a slight degree a loss of tone of the muscles of the right side.

The electrical reactions showed a quantitative diminution on the left side, but no qualitative change.

The knee jerks were active, more so on the right than on the left. There was no ankle clonus and no Babinski sign. Both Achilles tendon and reflexes and plantar reflexes were present.

There was an area of loss of tactile and pain sensation on the anterior aspect of the left leg. He complained at times of various paræstethic sensations in both legs. The urine showed no abnormality. The pupils reacted to light and accommodation. There was no disturbance of the cranial nerves. The nature of the lesion causing the disturbance was of interest. The symptoms might be due to an arthritic change (arthritis deformans) in the lumbar spine, to a neoplasm, or, considering the recent infection and inadequate treatment, to syphilitic disease.

The atrophy and pain with slight disturbance of the reflexes and very slight disturbance of the bladder indicated a lesion outside the cord. The rapidity of the onset of the symptoms and the great atrophy indicated a fairly rapid process. Tumors of this region as a rule give rise to more local symptoms.

In this case the diffuse nature of the symptoms seemed to indicate a more general process and considering the recent imperfectly treated syphilis it was considered advisable to place the patient on anti-syphilitic treatment. The result was that in ten days the pain and bladder disturbance had practically disappeared. The improvement except for a short time has since been practically continuous. The patient, except for atrophy of the left leg which was rapidly improving and some stiffness in the back which was relieved by adhesive plaster strapping, had so improved that he could return to work.

Conditions giving rise to symptoms of pressure on the cauda equina were of great interest, but as the present case did not throw any light on question of localization he would not do more than call attention to the importance of pain in both legs as an early symptom. Cases of specific disease of the meninges at times demand surgical interference, as it has been recently shown that diffuse syphilitic meningitis as well as localized gummuta, which did not react to medical treatment, afterward improved rapidly when some operation which would stir up the condition had been performed.

He wished to thank Dr. Hatch for taking an X-ray of the spine. This showed a deposit along the left side which looked similar to those seen in arthritic spinal conditions, while he had seen symptoms similar to those presented by this case present in a slight degree in arthritic disease of the spine. He was inclined to think the extensive atrophy and bladder disturbance pointed more to the specific disease. In this connection it must be remembered that almost any neoplasm would temporarily improve under mercury and potassium iodide. The future course of the case would prove the correctness or incorrectness of the diagnosis and whether or not we might not be dealing with two conditions.

DISCUSSION.

DR. HATCH (a guest of the Society) stated that when he first examined the skiagraph of the case presented by Dr. Van Wart he thought that the symptoms were due to osteoarthritic changes in the bones of the spine.

DR. SIMON had a case of arthritis deformans of the spine at the Charity Hospital, which had been diagnosed and treated as sciatica. There were no tender spots along the sciatic nerve. There was stiffness of the whole spine, with a characteristic attitude called stiff stooped back. The patient gave no specific history, but the use of iodides rapidly relieved all the symptoms, with the exception of slight stiffness of the spine. No treatment whatever had been directed to the sciatic nerve. No skiagraph was taken and it is therefore impossible to say whether these would have shown knots on the outside of the joints or merely bony formation between the bones.

Dr. Hatch: There are two forms of arthritis deformans of the spine distinguishable with the X-rays. One shows atrophy of all the cartilaginous parts; the other and most common form is a real osteoarthritic condition, or that of hypertrophy. A great deal of work has been done with the X-ray in diagnosing these conditions, and if they exist in the lmbar spine they invariably affect the sciatic nerve. Although there is no special reason for same, the affection seems to be always more marked on one side of the spine.

These cases are best treated by the plaster jacket or some other support. The cause of the increased formation of bone is not known.

Dr. Bass asked Dr. Van Wart whether mobilization or immobilization gave the best results in cases of arthritis deformans.

Dr. Bruns asked Dr. Van Wart what he called a very large dose of iodide.

Dr. Van Wart, in answer, said that he gave his patient as high as 100 grains of potassium iodide three times a day without causing symptoms of iodism. The doctor had seen about thirty cases of arthritis deformans of the spine. In only two of these were the symptoms anything like as pronounced as in the case presented tonight. Had that case been arthritis deformans he does not believe that the same amount of improvement would have followed antisyphilitic treatment. As stated before, the antisyphilitic treatment was followed by relief of all the pressure symptoms. One must always bear in mind the fact that tumors of any nature frequently improved for a time under this treatment. In reply to Dr. Bass, he stated that Dr. Hatch could better answer his question.

Dr. Hatch thinks that immobilization, in the early part of the treatment, gives the best results.

Dr. Bruns, referring to the case of Dr. Simon, wished to remind the members that, as a rule, the histories of patients are very unreliable, especially in regard to syphilis. He has often seen unmistakable evidences of former syphilis in the eyes of patients from whom no history of the disease could be extracted and in whom no other evidence of the disease could be found.

DR. J. N. ROUSSEL read a paper entitled:

A Case of Cheilitis Glandularis.

C. H., aged 36 years, a native of this State and city, presented himself for treatment at my office on January 7, 1906.

His complaint consisted of a very much tumefied condition of his lower lip, which involved the vermilion part of the lip only. The left portion of the upper lip was also involved to some extent. The lower lip was very much swollen and tense, and the mucous glands stood out very prominently, being about the size of small peas, with follicular openings much dilated, from which there was a continual ooze of an opaque mucous or muco-purulent secretion. Some of these openings, of which there were many, were quite large and indeed fistulous in character. Some would admit a large probe to the depth of a half inch or more.

The condition of the lower lip was especially distressing. Its mobility and contractility were almost entirely lost. It was three or four times its natural size, and rolled over upon itself from within, so that the mucous membrane touched the chin. This, of course, rendered the retention of saliva or any other fluid in the mouth an impossibility, which, coupled with the continuous mucous ooze from the lip surface, made it necessary that a handkerchief should be kept in service continually, with the natural result that life was not a "long sweet song" by any means.

In fact he was quite disgusted with life (for him it had only one phase), as the condition had existed for three long years, and apparently getting no better, if not worse, which was not destined to cheer his lagging spirits. This, however, he tried faithfully to do by an earnest appeal to the soul-soothing influence of that subtle agent commonly called booze, the effect of which was markedly futile and detrimental to both his general and local condition.

On the inner side of his lips there were several erosions of considerable size, which were apparently due to decayed teeth, of which he had quite a number.

Of his having had syphilis, he bore ample evidence. There were tubercular syphilides on his lips, chin, left cheek and forehead, which he said had had existence for at least a year, in spite of almost continuous medication with iodides, and, intermittently, with mercury. There were also some distinctly seborrheic lesions on the upper lip and left cheek, near the nose. These lesions have been found in nearly all of the reported cases of this distressing affection, while only four in ten of the recorded cases had had syphilis.

On the skin surface of the lower lip there were two ulcerated lesions of considerable size near the vermilion border, which showed no tendency to heal, owing to the juxtaposition of the redundant lower lip to the bearded area of the chin. These lesions were undoubtedly late ulcerating syphilides, as will appear below, but they were not of the classic type. Their appearance was more that of an ulcerating seborrheic process.

The general health of the patient was good, with the exception of what appeared to be a chronic malaria. He had occasional febrile attacks, which readily disappeared on the administration of quinine in sufficient doses. The condition began about three years ago, when he was severely salivated while being treated for a case of syphilis which he had contracted about six years before. The lower lip became much swollen, and remained so until the ptyalism subsided, when the swelling gradually disappeared. It did not remain so, however, very long. In the course of a few months he was again the victim of a mercurial stomatitis. This time the lip swelled again to a size somewhat larger than it had previously, and there it remained practically unchanged until he came under my care.

His teeth did not belie his statement. They had certainly outlived their usefulness, so to speak, and, while a few of them were firmly fixed in their alveolar processes, their condition was such as to render them a constant menace to the surrounding parts. The tongue, beyond a few indentations caused by the teeth, was not involved in the process. The general condition of the mouth was good with the exception of the few erosions on the inner part of lower lip, mentioned above. Exactly what the condition was I did not solve for some days. I had not seen anything that resembled it before. In truth, to use a common expression, I was "up the proverbial tree." I could not find anything in the literature of the diseases of the lips, at my disposal, that in any way tallied with this case, but after searching diligently for several days I was rewarded by finding the condition described in detail in Stelwagon's book on *Skin Diseases,* under the title of "Cheilitis Glandularis,' or "Myxadenitis Labialis."

The condition certainly resembled that described by Stelwagon as closely as possible, and my mind was soon relieved of any doubt but that the condition in question was a genuine Simon Pure case of myxomatous degeneration of the mucous glands of the lips, or a cheilitis glandularis.

I did not have a microscopic examination made. I did not think it wise to take away any part of his lip, in spite of its size, to satisfy my curiosity. I was morally convinced that, be it that or something else, the treatment would, in all likelihood, be the same. The handwriting, so to speak, was on the wall. Time had wrought the indications, and it was clearly imperative that at least four things must be done, and done in the order named. Destroy the mucous glands, to relieve the continual ooze; extract the decayed and broken teeth, to remove their irritating influence; treat the underlying syphilis, and last, but not least, make every effort to restore contractility to the orbicularis oris muscle.

The mucous glands I destroyed with an iridio-platinum needle attached to the negative pole of a galvanic battery. The first application was not as successful as I had anticipated, but after having subjected the glands to the action of the current three or four times (using a current strength of 60 M. A.) it was quite evident that some good had been accomplished. They ceased to ooze, the inflammatory exudation induced by the disease and that caused by the action of the current was noticeably melting away, and in a general way the condition showed marked improvement.

The teeth I had all extracted with the exception of the two bicuspids below. These were fairly sound and firmly fixed in their respective processes. They were thoroughly well cleaned and polished, to render them as unirritating as possible, and a rubber plate was made to fit over them and line the inner side of the lower lip. Against this, by means of an adhesive plaster strip on the outside, more or less continuous pressure was maintained for the purpose of keeping the lip in position and favoring the absorption of the inflammatory exudate. I sometimes used collodion with satisfaction. The orbicularis oris muscle was exercised daily by means of the interrupted faradic current (20 interruptions per minute) for about five minutes, followed, for about three minutes, by galvanic current, with a view of favoring absorption and resting the fibres of the orbicularis oris. The result of this whole scheme was truly marvelous. In the course of about one month he had regained perfect control over his lip. It was half its former size; the muscle had regained its contractility almost entirely, and he was able to close his mouth, an act he had not been able to accomplish for many a long day. At the same time he was able to dispense with the use of the handkerchief, above mentioned; he could eat and drink comfortably and in every way he was markedly improved.

The syphilides, however, had not improved to any extent. They were all there, and I then began the administration of the protoiodid of mercury, one-quarter of a grain three times a day. This was increased until he was taking one and three-quarter grains per diem, and resulted in salivating him. The mercury was stopped, a mouth-wash given him, and in a few days he was relieved. During this period the ulcerations on the lower lip healed, but in a few days one of them broke down again, whereupon I began the administration of the protoiodid for the second time, together with a thirtieth of a grain of arsenious acid, which he was able to continue, without ill effects, even to taking one and three-quarter grains over a long period. The iodide of potash was tried on several occasions, but the lip invariably got worse. Volkmann claims to have cured three cases with the iodide of potash. Others have not been so fortunate. Purdon, who reported four cases of this malady, was unsuccessful with the iodides. He obtained his best results with the application of lotio nigra and glycerin, and an occasional penciling with the nitrate of silver. He does not claim to have cured any. As far as I can discover, destruction of the myxomatous glands by the electric needle has not been done in any previous case, and, while I do not wish to lay any particular claim to the method, I think it by far superior to that in which drugs alone are employed. As a matter of fact it is practically impossible to reach the fundus of such glands with drugs, and less possible to accomplish anything if we do reach them.

I last saw the patient on April 6, 1905. He was then, for all intents and purposes perfectly well. His lip was about its normal size, and the syphilides had all disappeared. He was, according to his own statement, a new but toothless man. Owing to the mechanical effect of the latter condition, there was some slight eversion of the lower lip, which would undoubtedly be corrected by the insertion of false teeth. This he said he would have done at an early date.

I have not seen him since, but his wife informed me recently that his condition was still very good, though he had not had his teeth put in.

Before concluding, I want to call particular attention to the fact that while syphilis was present, it had no apparent effect upon the condition, it having disappeared without the aid of antisyphilitic remedies. This is in line with the experiences of others. It does appear, however, that the mercurial stomatitis was the exciting cause, and I trust it will serve to emphasize the importance of using mercury less freely in conditions about which we are in doubt.

DISCUSSION.

DR. WALET saw this patient before the treatment and wished to congratulate Dr. Roussel upon the splendid results obtained.

DR. GESSNER asked how frequent this condition was.

DR. ROUSSEL replied that only ten cases had been reported, this one making the eleventh. Several years back a patient, an inmate of the Charity Hospital, supposed to have been afflicted with this condition, was treated by amputation of the lower lip.

DR. C. M. BRADY read a paper entitled

The Circumstances and Conditions of the First Appearance of Yellow Fever in New Orleans and Country Parishes.

A general résumé of the prevalence of yellow fever in the country, as it came before me in the performance of my duty as medical inspector for the Louisiana State Board of Health. From certain investigations that I have made, and from the published opinion of the City Health Officer, I am led to believe that yellow fever unrecognized must have first occurred here about the middle of May. Whether imported earlier in ships from Colon, Belize or Havana no one seems able to determine. Two deaths which I now believe to have been yellow fever occurred in June. About July 1 and 2 three Italians died after a short illness at 1107 and 1205 Gallatin street, a short street near the United States mint. They were seen by the coroner, whose suspicions were evidently not aroused. During the next twelve days till the suspicious fever was made known to the authorities there were probably four or five additional deaths in New Orleans of yellow fever, most of them at hospitals. The fact of its first appearing near the French Market and in and about the large Italian boarding houses of that neighborhood, coupled with the well known migratory and secretive characteristics of the Italian, will explain the reason for the rapid spread to the country and its consequent presence there before it was recognized, not to say reported in New Orleans.

THE EARLY CASES IN THE COUNTRY—LAFOURCHE PARISH.

Camile R., the largest merchant at Leeville, Lafourche Parish, came to New Orleans about the first of June and tied up with his lugger at the landing near the French market; he is said to have heard reports that there was yellow fever in that neighborhood, but as he was an immune he thought nothing of it. He returned to Leeville with none of his crew sick, so far as he knows. In about fifteen days several members of his family were taken sick, and later others except himself and those who were immunes of 1878. This fever spread in both directions, up and down the bayou, from his general store as a focus. Later, on July 1, Clovis Terrebonne came to New Orleans and visited around the same neighborhood, returning July 5. He was soon stricken and died July 17. It was noticed that none of those who had this summer fever, as it was termed from the Robstock infection, afterwards developed yellow fever.

CONDITIONS IN ST. JOHN.

The first outbreak of yellow fever in St. John Parish presents the following history as clearly set forth by Dr. S. Montegut, the physician in charge. An Italian came from New Orleans Sunday, June 26, to visit relatives. Tuesday, June 28, he was stricken with an attack of fever that the doctor considered very suspicious of yellow fever. Three days later the 14-year-old boy, resident of the house, who had not been away, was stricken with the same fever, with more pronounced symptoms, hemorrhages, albumen, jaundice, etc. This being correct, one would believe that the Italian from New Orleans was bitten by an infected mosquito as soon as he arrived in St. John, and that the infection had been transmitted to St. John Parish some fifteen days earlier. However the circumstances, Dr. Montegut was so impressed that he screened each patient as soon as stricken and five days later fumigated the house with sulphur. There were no other cases in that house until August 18. Some miles above, June 25, a young man, native born, was taken sick four days after visiting New Orleans, and died in five days with jaundice and hemorrhages. This is believed to be the beginning of the infection of the upper part of that parish. In passing, a last case of a severe type went down on Christmas day. While Dr. Montegut suspected yellow fever at the time and even went so far as to fumigate the premises, he well hesitated, when it came to report the presence of yellow fever in a country parish when there was no breath of suspicion of this disease anywhere in the South. These two places, Leeville, in Lafourche Parish, and the east bank of St. John, where the yellow fever first appeared outside of New Orleans, were affected with the severest epidemic in the State in proportion to the population.

FIRST OFFICIAL RECOGNITION IN THE COUNTRY.

To Dr. Menville of Houma belongs the credit, so far as is known, of making the first positive diagnosis of yellow fever in a country parish, on the Ardoyne plantation of Mr. John D. Shaffer of Terrebonne Parish, July 10.

The history of the beginning of this local epidemic, as given by Mr. Shaffer, is as follows:

On June 20 an Italian, Leon Lescale, went to New Orleans for treatment of his eyes; July 2 Victor and M. Lescale came to the city, where they stayed with the first mentioned at 523 St. Philip street, returning July 4. On the 6th Victor Lescale was taken sick, dying July 14. Leon returned from New Orleans on July

11, very weak and very yellow, and reported he had been quite sick. The subsequent spread of the disease on this and neighboring plantations, even to the outskirts of Houma, is an old story.

Caspar Brown, a resident of Clark Cheniere, in Jefferson Parish, came to New Orleans to be treated for an injured hand. He spent a number of days there and visited several friends, sleeping at 626 Ursuline street. He was taken sick as soon as he returned home, July 15, with the later infection of the little village to the extent of forty-four cases and three deaths out of eighty-five to ninety individuals. Thus we have two communities infected by sick people going to New Orleans for treatment.

At Diamond plantation, in St. Charles Parish, an Italian died July 16 who was taken sick one week earlier, and another died at the Charity Hospital from that place on July 9 with what is known to have been yellow fever.

When I visited Bayou Natchez, a small village in Natchitoches Parish, a young man was presented to me as the first known case of fever and the statement made that he was taken sick July 8. He claimed not to have been out of that neighborhood for some months previous. If his claim was correct he must have been infected by an unknown Italian who was sick about June 20, as subsequently happened at Patterson, Riverside plantation, and Bon Ami. Evidently yellow fever had been spread to the six localities before it was known in New Orleans, Leeville, Bayou Natchez and St. John Parish late in June, Ardoyne plantation July 6, Clark Cheniere July 15, and Diamond plantation early in July.

EARLY RECOGNITION OF THE DISEASE IN THE COUNTRY.

As a rule in Louisiana the disease was recognized with commendable promptness, as at Bunkie, Lake Providence, Port Barrow, Elizabeth plantation, Tallulah and Bowie and other towns. In some localities, as at Gros Tete, Bayou Natchez, Patterson and Kenner, the first cases were mild, as they were in New Orleans. Physicians were not called to any extent, and the disease was not recognized before the second or third infection.

Some Details.

At the risk of tiring my hearers I shall relate the manner of its introduction and spread in the village of Gros Tete.

Charles D. and Frank B., Italian fruit vendors, went to New Orleans to make purchases and returned July 22, the day that yellow fever was declared. They at once shut themselves up in their respective homes, where they remained invisible for some ten or more days. The neighbors were much alarmed at their disappearance after their return, and went so far as to discuss an effort at finding out if they were sick. In the meantime they met every train on the Texas & Pacific Railrad with the ubiquitous shotgun for fear some reckless traveler would try to get off, health certficates or not.

Nothing came of their plans to learn the reason of the Italians' seclusion. They were more strenuously engaged in keeping the fearsome stegoymia from escaping off trains in valises and suit cases or out of fumigated boxcars. In the meantime the Italians reopened their stores, looking a little pale perhaps; customers began coming in, and the suspicious circumstances were forgotten till the facts of the outbreak were revealed to me after a considerable investigation.

The cases occurred in this order:

1. Aug. 12, twenty days after the return of the Italians, Miss L., a customer, was taken sick with typhoid fever. (Diagnosed as such.)

2. Sept. 1, Mrs. H., a customer, went down with fever. The husband diagnosed it as yellow fever—no doctor.

3. Sept. 2 and 9, A. L. continues sick in store; brother of Miss L. relapsed the ninth day and was quite sick at home afterwards.

4. Sept. 12, Percy J.; Sept. 13, J. D., two friends, bought fruit in store and who were infected at the same time.

5. Sept. 19, Phyllis H.; 6, Sept. 18, Lawrence; 7, Sept. 17, Madam H.; 8, Sept. 19, Nola H.—all taken sick fifteen to seventeen days after L.'s attack at the store, which is only a distance of thirty feet from H. house, with windows opening across from each other. None of the four had been in the store.

9. Sept. 16, Alfred H., sixteen days after infection of mother in same house.

10. Sept. 18, Mrs. D., eighteen days after infection of mother in same house.

11. Sept. 18, Mrs. B.; frequented infected store sixteen days after infection.

12. Sept. 18, Mrs. B.; visited Mrs. H. on Sept. 15.

13. Sept. 18, F. L., clerk in infected store; sixteen days after infection.

14. Sept. 20, Miss A. L.; at home; house infected already.

A total of sixteen cases infected as follows:

First infection, four cases traced directly to the Italians.

Second infection, two cases from Miss L.

Third infection, three cases from Mrs. H.

Fourth infection, six cases from infected sore through Mr. L.

When yellow fever was recognized in the person of young J. and H., who were frequently around the depot and off and on trains, it took a vigorous search on the part of the local health officer and myself to trace out the infection, and to prove to the satisfaction of the people of Gros Tete, and consequently to the people of Louisiana, that the infected mosquitoes were not brought to Gros Tete in freight cars or passenger trains.

Here I wish to impress this fact, in no case anywhere in Louisiana did I detect one instance where I was sure that infected mosquitoes traveled further than the next house or a few feet away, except the thirty feet from the infected store to the Hotard, where the mosquitoes were driven out of the infected houses by bad fumigation and sought refuge at the next neighbor's.

As an axiom yellow fever is not carried by infected mosquitoes, but is transmitted through some individual traveler, not by mosquitoes blown through the air, but on a pair of shoes.

An Awful Example.

As an example of how easily yellow fever is mistaken and as a warning for others to avoid such an error, I desire to again trespass on your time by mentioning a few cases.

On July 28 an Italian family left the house 531 Dumaine street and went to a country residence about thirty miles from New Orleans. Their presence was at once made known to the local authorities and a nearby physician employed to see them twice daily and take their temperature.

July 30, forty-eight hours after their arrival, one refugee was taken with a temperature of 103 in the morning; about normal at night under treatment.

July 31, second case temperature 101 1-5 in the morning. This fever lasted two days. Both soon recovered and were discharged.

Aug. 15, sixteen days later, a child was taken sick.

Aug. 16, another one taken sick.

Aug. 18, and so on; Aug. 20, with records kept carefully; Aug. 29, and temperature taken daily.

Aug. 31, one who died with uræmia and black vomit on Sept. 6.

Sept. 3. Miss K., who lived three miles away and visited the family on Aug. 30.

Sept. 5. The colored wash-woman next door.

Sept. 6. Another member of the family.

Here we find a physician employed by the parish authorities to watch for yellow fever among suspects who treated this disease and kept records with usual care, but did not suspect yellow fever till convulsions and vomiting of blood in a man as yellow as saffron occurred. He could not realize this mild fever lasting only one or two days could be yellow fever.

Again I urge the absolute necessity of suspecting any group of fever of the same type occurring in a family or immediate associates.

GOOD WORK IN CONTROLLING DISEASE.

In the majority of infected localities where the fever was not almost already an epidemic before it was discovered, it was either stamped out or controlled. Witness detention camp near Shreveport and such towns as Alexandria, Donaldsonville, Lutcher, Gros Tete, Morgan City, Westwego, Baton Rouge, East Natchitoches and others.

APPEARANCE AMONG THE NEGROES A CAUSE OF ERROR.

A chief cause of doubt as to the existence of yellow fever and its consequent spread in some town was due to the early appearance among the negroes and its slow recognition in that race.

Three towns (Bunkie, Tallulah and Bon Ami) were declared free of fever by competent observers, and the quarantines removed, when it had only been stamped out among the original Italians, and had made its way to their negro associates. In the first mentioned town I learned that fever lasted until Dec. 10, in occasional cases. To this difference of opinion and inability to recognize the disease among the negroes and to the removal of the quarantine is due the later infection of several neighboring communities.

I found this summer a very considerable tendency among the physicians not to suspect yellow fever unless there was rather marked jaundice or black vomit, and as both of these are rare in negroes, I found it very difficult in certain towns where yellow fever was present among them alone to convince some physicians.

ODD AND UNUSUAL CONDITIONS IN JEFFERSON.

Conditions for checking fever were more favorable in some localities than others. For instance, the five Grand Lake fishing platforms in Jefferson, Parish under charge of Dr. W. L. Richards. The platforms were built on piles about eight feet high over the marshy edge of the lake, salt sea water one foot or more deep under each platform, without a drop of sweet water within fifteen miles except that contained in cisterns and barrels on the platforms. Here we had a mixed population, which, numbering nearly 1,000 of Chinese, Filipinos and whites of various races, lived on five different platforms, each a mile or two from the nearest. There was no necessity of visiting or infecting each other's camps if it had not been for their ungovernable gambling propensities (fan tan, cotch and the like). I recall one camp that remained free of fever. It was ruled absolutely by an old Chinese mogul or mandarin who allowed no intermingling with other camps or intercourse with New Orleans. In truth I have a more than vivid recollection of the rush of a drove of Chinamen, some of them bearing shotguns and Winchester rifles, who commanded my relief boat in vigorous Chinese expletives that we were not wanted.

The infection at these points was brought directly from New Orleans at various times; one gasoline boat brought down 15 fishermen to the different camps Aug. 21, and 8 of the number were taken with fever within five days after their arrival.

Each platform reared a little epidemic to itself and was succeeding nicely when Dr. Richards took charge. He cleared the fever out and left in twenty-six days.

A sad story comes from the Cheniere Caminada, the scene of the great storm of 1893. During the heavy winds and high tides of October a young woman, on the fourth or fifth day of the disease, ran out of her home through sea water to her hips to seek the same refuge in which her life had been saved that terrible year. This effort cost her her life.

WORK OF THE COUNTRY DOCTOR.

During the past summer, from the 20th of July to the 20th of November, I visited 23 parishes and more than 70 localities, many of them the second or third time. I diagnosed officially and reported yellow fever 32 times, found none where suspected in 16 instances and inspected the remainder.

In view of my experience this past summer in helping to combat the fever in the country, I desire to congratulate and pay a tribute of praise to the medical profession of the country. I wish to recognize the character and the professional attainments of the men, the average men in the country, who made the fight against yellow fever, whether in an official capacity or otherwise. They were underpaid and overworked. Non-immunes mostly, men like Bernard at Lake Providence, Gaines at Tallulah, Anderson at Tallulah, Barnett at Bon Ami, Shanley at Barataria, who paid with his life the penalty for attempting to return to duty too soon after his recovery. Who can forget his simple question, when urged to wait until he was stronger: "Who will look after my poor people?" Barnett, Anderson and Shanley, the three martyrs.

It was a different condition in the country, with infrequent trains and without necessary drugs or sulphur, or with scanty resources or supplies and lacking trained assistants. A doctor often sleeping among infected houses, never knowing when he would be stricken, perhaps the only physician in forty to sixty miles. Yes, I repeat, it was a different condition that presented itself from that of New Orleans, where the fight was made with the aid of the United States Government and almost unlimited money.

EXTREME DIFFICULTY OF DIAGNOSING YELLOW FEVER IN THIS AND OTHER YEARS.

In closing, I wish to again lay stress uopn the extreme difficulty of diagnosing yellow fever at any time unless one has it in mind. In 1898 I treated yellow fever from the latter part of July until Sept. 6, when I, as others, mistook it for dengue. I believe this has been continually done in Louisiana, Cuba and Mexico and other States of the South in this and recent years.

That type of fever that spread through the northern part of Mexico in certain towns in 1903 was diagnosed and treated as dengue for months, but when it crossed the Rio Grande into Texas and 17 cases had been called dengue there, it had assumed all the types of an average yellow fever epidemic and was so diagnosed by the authorities of Texas. I would rather infer that from the subsequent history of the outbreak this so common error in diagnosis was unintentionally committed this year in Havana. First, many cases of dengue and afterwards, very suddenly, yellow fever crops up. Dengue when they recover and pernicious malaria fever when they die. I saw recently a report sent in from a small Cuban town by the representatives of the P. H. & Marine Hospital Service of an autopsy on a cadaver which showed acute nephritis and gastric ulcer. I wonder if this could not have been uremic convulsions and black vomit? Perhaps we all remember the dengue that was epidemic in San Antonio, Galveston, Seguin and other towns in Southern Texas in 1897, and if so, can recall the article on dengue in Galveston by Dr. Geo. H. Lee, in the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, where he lays stress upon the albumen, extreme weakness, slow pulse, jaundice and hemorrhage, but the absence of black vomit assures him it was not yellow fever; a hemorrhage from the bowel in one case was explained satisfactorily to him.

FAILURE TO DIAGNOSE YELLOW FEVER IN MISSISSIPPI IN 1905.

Take again the recent epidemic of the Mississippi Gulf Coast, when as competent a man as Surgeon Wasdin of the U. S. P. & Marine Hospital Service failed repeatedly and regularly to find yellow fever, even reporting as late as August 15 that there was not a case in the State of Mississippi when, as a matter of fact, yellow fever had already appeared in 8 or 10 towns in the interior and on the coast. It doese not seem fair when such mistakes are made by such able men as Surgeon Wasdin, when yellow fever is known to be epidemic within 60 or 80 miles, to blame either the doctors of New Orleans, not experts, nor country physicians who perhaps have never seen a case of yellow fever in their lives, when they fail to recognize and report yellow fever.

METHOD OF FUMIGATION AND REASONS FOR SOME FAILURES THIS YEAR.

Under the light of previous experience in this State and in others, I see no reason to escape fever in some of the localities where it was especially prevalent, or in some places where it was not recognized, or in few places where it was doubted and denied by some even after it was reported, unless vigorous methods are put in force to kill mosquitoes this winter. To do this I suggest prompt fumigation be carried out at each cold wave this winter so as to force the infected mosquitoes out into the cold air by burning sulphur in all houses in every community where fever of any kind prevailed. At several places this summer at the beginning of the fever an insufficient number of houses were fumigated, which caused the infected mosquitoes to seek refuge in the nearest non-fumigated house This resulted in infecting the neighbors when the original infected family remained free of disease or was taken later in the outbreak. This fumigation, while carried out by local authorities, should be under the supervision and eye of the State Board of Health for the reason that while in the great majority of communities this work was done as well as possible under the circumstances last summer, in some the lack of money, or the non-belief in the mosquito theory on the part of a health officer, has allowed none but a very meagre fumigation.

HOW TO STAMP YELLOW FEVER OUT SHOULD IT DEVELOP.

I recommend in addition to this fumigation of the winter that beginning about the middle of May or as early as the new crop of stegomyia begin to come active, one or more competent diagnosticians of yellow fever visit and see the fever cases at intervals of about 20 days in each of these 70 communities where fever has prevailed, and continue to do so until cold weather puts an end to the danger. Should this expert or local health officer find or suspect yellow fever, it should be reported at once to the State Board of Health and competent diagnosticians be sent to watch and examine the case till a positive diagnosis is made; certainly till such a number of infected communities have been found that there can be no doubt of the nature of the disease.

Furthermore, the State Board of Health should have special physicians who are experienced in fumigation against the mosquitoes and several expert fumigators ready at a moment's notice to proceed to any part where yellow fever is diagnosed. The physicians are to take charge of the outbreak, acting in conjunction with the local health officer, and remain till the fever is stamped out.

Another important and especially important point is to be sure a town is free of fever in fact instead of name before the quarantine bars are taken down. Where many business interests are at stake and doctors are disagreeing, individuals are arguing with and importuning him, it is difficult and even unusual for a local health officer to declare the presence of yellow fever unless upon the most positive proof, and even when the first case is reported and, as a rule, dead, it is so easy to mistake the new cases, which, as I have said before, frequently occur among the negroes.

With a plan in some manner modeled upon these suggestions, yellow fever can be kept from spreading should it develop, and, best of all, can, I believe, be prevented from developing.

DISCUSSION.

DR. NOLTE said that, referring to the fever situation which existed in the interior of Texas last summer, he believed that all these cases reported as dengue were truly dengue. He saw several hundred cases of the disease himself. In San Antonio, Texas, there were 20,000 cases without a single death and he hardly thought that this could have been yellow fever. He did not know what the cases of fever in the southern part of Texas were.

DR. BASS did some work in Tallulah last summer and did not believe that there could be any doubt that yellow fever at that place had been early recognized. Unfortunately, before the diagnosis of the health officer, Dr. Gaines, had been concurred in by experts, who went there as such, thirteen squares, inhabited chiefly by negroes, had become infected. He believed that the danger to a community was not so much from the sick negroes, who had to remain in bed, but from those who, although sick, were still able to go about and carry infection, walking cases, or those still in the incubation stage, but able to carry infection. The yellow fever hospital equipped at Tallulah was thoroughly screened with cheese cloth and even after three sulphur fumigations by U. S. P. & M. H. service, living stegomyiæ could still be found in the building. This, he thought, was due to the fact that when the window sash was let down for fumigation a space existed between the screen and sash in which a few mosquitoes were protected against the fumigation. These, of course, were let back into the room when the sash was raised.

Dr. H. P. Jones said that a New York paper published a report that yellow fever had been brought to Havana from New Orleans in a consignment of electrical goods. The doctor stated that their experienc at the Emergency Hospital at New Orleans was unquestionably proof that yellow fever mosquitoes cannot live without water. In this hospital a thorough system of plumbing had been instituted and no water of any kind was accessible to the stegomyia. After a thorough and repeated fumigation, careful examination of the sweepings from the walls and floors of the institution revealed the presence of a few dead stegoymiæ, but no living ones.

Dr. Simon: Can mosquitoes hibernate?

Dr. Nolte: It is believed that mosquitoes can hibernate and live throughout the winter without water.

Dr. Gessner: A new outbreak of yellow fever in 1906 might be prevented if the State Board of Health went over every one of the 70 or 80 infected towns and had them carefully watched early in the spring.

Dr. M. M. Lowe wished Dr. Brady to state the important diagnostic points, which he thought, after all, were the essential things which the general practitioner wanted to know when at the bedside.

Dr. Brady: In answer to Dr. Simon, mosquitoes evidently hibernate and whenever the room gets warm they revive and bite. As an example, one case of yellow fever was reported on January 8, 1906, and if the diagnosis proves correct, he will have another case to report to-morrow, January 28. In Gretna, La., there were about 1,500 cases of yellow fever, with only one death, and he believed that the cases in San Antonio might have been yellow fever, although there were no deaths.

Communications.

Typhoid Fever is Preventible.

Dr. Menville says that typhoid fever is spreading in the country; if that be true, I have placed myself in a bad way with my patients and constituents, for I have repeatedly told them that it was a moral crime for anyone living in the country to allow typhoid fever to appear and remain upon their premises, and that I hoped it would some day become a crime in sight of the law. I have been practicing medicine in the country twelve years; during that period have treated about thirty typhoid patients. All recovered. I have not seen a case within two years. In every case I have succeeded in locating the origin, pointed it out to the family, and had it stamped out. I admit that it is not always an easy task for the physician to hunt down these pest holes, but it is his duty to do so, and prevent further infection. I will mention a series of cases in which I was twelve months in locating the enemy's headquarters, but I never despaired. In the spring of 1902 I was called to two cases of typhoid fever in a family of seven. Patients were children, ages respectively 8 and 10. Temperature ranged from 103 to 104 F. After putting them on physical treatment we charged the water works, which was a large overground cistern; emptied and thoroughly disinfected it, then used pine tar on bottom and partly up the insides; we then took a general survey of the premises, cleaning under all buildings, burning debris, and used slacked lime freely. My patients ran an uninterrupted career, made a good recovery. In a few days two more cases developed in the same house. I naturally suspected that they were infected by the previous cases; these ran a mild course and got well. After an intermission of a few weeks another case developed. I then began to suspect that we had not yet destroyed the source of infection; so we had another general cleaning up; a second time emptied the cistern. After a short while there were still other cases in the house, though they were so mild that I was not consulted. The father continued previous treatment. I only saw these incidentally. This was more late in the fall. Next spring I was called to see two more cases in the same house, these being the two who were first taken, now having a second attack. I was then convinced that the origin or pest hole was still existing in close proximity to the dwelling. With renewed energy we started another campaign of disinfecting. There stood in our very midst, most prominent at one end of the dwelling, an old dirt chimney, which had fallen into disuse, the fireplace having been ceiled over and painted, made it somewhat unnoticeable. We had it torn away. The scene in the chimney and fireplace was sickening. There was an accumulation of bird and rat dung of several years' deposits, from which emanated a most repugnant odor. The old debris was burned and otherwise disinfected, which ended typhoid fever in that family. We believe the disease here was transmitted in several ways, by washings from the top of chimney into the cistern, by birds and rats traversing the roof, contaminating the milk and other foodstuffs, where it was accessible, and by inhalation or direct contact, for those sleeping in the room which approximated the chimney were the first to develop fever, and in its worst form. We have now gone over the most important part of the treatment. As to physical treatment or medicine proper, that is simple. Clean up your patient and repeat frequently. Give fresh air. Disinfect all excretions. Reduce high temperature with cool sponge or dip bath. Give absolute liquid or predigested nourishment, including alcoholic stimulants. Medicine:

℞—Castor oil, f ʒ iii.
Spt. turpentine, M iv.
M. Sig. Give every six hours.
℞—Copper arsenite, gr. ½
Distilled water, f ʒ vi.

M. Sig. One teaspoonful every three hours, or granules of arsenite of copper gr. 1-100, varying dose according to age. May also give listerin and glycerin equal parts in connection with the others. When temperature is declining from one-half to one degree F. a day and patient is otherwise doing well, you find on another visit that temperature has gone up two or three degrees. Don't ask any questions, thereby tempting anyone to make a foolish statement, but positively forbid further giving of solid food and start your work all over, as it were, in a new case.

Wth our knowledge of the source of infection and with the means we have at hand for preventing and treating typhoid fever in the country for one to lose a patient whose physical condition is otherwise fairly good should produce a suspicion of neglect on the part of someone. T. B. Odom, M. D.

State Quarantine.

Bureau of Public Health and Marine-Hospital Service.
Treasury Department, Washington, Jan. 16, 1906.

Editors of the New Orleans Medical and Surgical Journal, New Orleans, La.

Sir—In your issue for January, 1906, you publish an article on "State Quarantine," by Dr. Arthur Nolte, in which a number of misstatements are made which I think in justice to this service should be corrected, and I therefore transmit the following, to which I trust you will give space in your journal. Dr. Nolte states:

> "The Marine Hospital Service was established in reconstruction periods; * * * medical men who entered this service were at times required to pass a not difficult examination, and some even obtained a position therein who were not graduates in medicine. * * * And through the maintenance of a powerful lobby at Washington the powers and duties of the service were increased gradually until Congress passed the Act of July 1, 1903, and it blossomed forth as the Public Health and Marine Hospital Service, and the personnel thereof were given the rank and pay of the officers in the army."

The Marine Hospital Service was not established in the reconstruction period, but was established in 1798; it was reorganized by Act of Congress, 1870-71, and since that date I know of no one who has obtained a position in the medical corps who was not a graduate in medicine, except in one instance, where a man was employed for special duty as a sanitary inspector and some time afterward obtained his diploma from an accredited medical college. The Act of Congress which changed the name of the service to "Public Health and Marine Hospital Service" was not that of July 1, 1903, but of July 1, 1902, and the personnel of the service were not given the rank of officers in the army.

The paper referred to further says:

> "In August, 1893, yellow fever was actually brought into the town of Brunswick, Ga., by the Marine Hospital Service, and the epidemic which resulted therefrom lasted until November."

That this statement is incorrect may be seen by referring to the report of Surgeon R. D. Murray, now deceased, on this very subject, published in the annual report of this service for 1893, Vol. II, page 33. There was a case of yellow fever in Brunswick as early as June 17, 1893, in the person of the captain of the ANITA BERWIND. The service officer did not take charge until July 31; and, moreover, it was shown that ballast crews had been in the habit of discharging Havana vessels and returning to the city after the discharge of ballast.

Dr. Nolte's paper further states that in 1897 yellow fever first appeared in this country at Ocean Springs, Mississippi, having been brought there by Cuban filibusters through the lines of the Marine Hospital quarantine at Ship Island to Ocean Springs, and from there spread to New Orleans and Mobile. This old story has been repeatedly proven incorrect. There has never been any evidence showing that the Cuban filibusters brought this fever to Ocean Springs, and so far as the Ship Island quarantine is concerned, I have only to refer to the report of a committee appointed by the Legislature of Mississippi to investigate the charges that were made against the United States quarantine station, and which report frankly and fully exonerated the station from any lapse of quarantine; and also to a report of a committee of the United States Senate, which visited the station and also vindicated the administration of said quarantine. Both these reports are published in the annual report of the Marine Hospital Service for the fiscal year 1898, pages 534 *et seq.*

Referring to the epidemic of the present year, the paper further states:

> "The Marine Hospital officer at Belize gave clean bills of health from that place from the beginning of the season, April 1, to May 24, nearly two months, by which time yellow fever was epidemic in Belize."

The acting assistant surgeon at Belize did telegraph on the 24th of May, on the occurrence of the first known case. How many cases there were preceding the first case it is impossible to determine. Not only was it the first case known to the acting assistant surgeon, but, as testified to by an agent of the service sent to make inquiries, the first recognized case in Belize. From May 24 to Nov. 30 there have been but ten cases and seven deaths officially reported at Belize.

It may be mentioned that Acting Assistant Surgeon Carson at Belize, who died of dysentery, was a man of special experience in yellow fever ports, was from New Orleans, and when first appointed acting assistant surgeon was at the time employed as medical inspector by the Louisiana State Board of Health.

Dr. Nolte further refers to the bubonic plague which appeared in Chinatown, in San Francisco, in 1900. He states that clean bills of health were issued by the Marine Hospital Service from that port while the plague existed. This is not correct. The Marine Hospital Service never issued a bill of health of any kind at any port of the continental United States. There is a custom house bill, with which the service has nothing to do, but on learning of the incorrect issue the bureau took up the matter and the Secretary directed its correction.

Referring to the commission of eminent specialists sent out by the Treasury Department to San Francisco to investigate the existence or non-existence of the plague, and the report thereon, Dr. Nolte inquires:

> "What did this commission sent out from Washington do when the entire country was most anxiously waiting for results of their investigation?"

In answer to his own inquiry he quotes, "*verbatim et literatim,* from a letter of the Surgeon-General of the Marine Hospital Service of March 26, 1901, replying to a request of the State of Louisiana, through its proper health officer, for a report of the commission," as follows:

> "Referring to your letter of the 21st instant, requesting a copy of the report of the commission sent to San Francisco for the purpose of investigating the existence or non-existence of plague in that city, I have to inform you that said report will be shown to any personal representative of yourself who may apply at this office, but cannot at the present time be sent out."

This question leaves out the last two lines of my letter. The letter closed as follows:

> "Attention is invited to the table of plague published in the last issue of the Public Health Reports."

Dr. Nolte further states that the report of the commission

"Was *never* made public or made known to any State officers concerned."

And inquires:

"Could there be a more dishonorable act on the part of the Government then to withhold this important knowledge for political reasons?"

An examination of the annual report of this service for 1901 (pages 537-9) and of the Public Health Reports will show plague was officially reported and published from March 6, 1900. In Public Health Reports of March 22, 1901, page 579, will be found a list of the cases of bubonic plague found in Chinatown by the commission referred to in Dr. Nolte's paper, and in the same Reports, March 29, 1901, page 636, will be found a brief synopsis of the work of this commission and a list of the cases they found, and in the number published April 19, 1901, pages 801-16, will be found the full report of the commission, which was soon afterwards published in pamphlet form and sent to all parts of the country.

Moreover, the existence of bubonic plague in Chinatown was reported by the Secretary of the Treasury in his report to Congress of Dec. 4, 1900.

Besides these published reports, individual letters of information were sent to the States in close communication with San Francisco, including Louisiana, and to the health authorities of Canada and Mexico immediately after the result of the commission's work was received.

Dr. Nolte in his paper intimates that the vessel named the CURACOA carried the plague from San Francisco to Mazatlan, Mexico. This has never been proven, and the presumption is as great that the plague was not transmitted to Mazatlan from the United States at all, but from some South American country, in evidence of which we know that plague existed in Brazil and Argentina and reached Valparaiso in 1902.

There are other statements in Dr. Nolte's paper that might also be corrected, but this communication has already grown to a greater length than was expected. Respectfully,

WALTER WYMAN.

P. S.—As the same article was also published in the New Orleans Picayune of January 2, 1906, a letter similar to this is written also to the editor of that newspaper. W. WYMAN.

N. O. Medical and Surgical Journal

Editorial Department.

Chas. Chassaignac, M. D. Isadore Dyer, M. D.

Quarantine and Sanitation.

The solitary position of our Texas friends in the matter of Federal Health Control must needs have some explanation, and we presume that a defense of their attitude will gradually assert itself. The evils of conflicting authority are perhaps outweighed considerably by the final result obtained by the exercise of an authoritative authority.

With this idea to juggle with, we are forced to reflect over the mass of good which has accumulated as a result of education of the people themselves. The recent Health Conference at Alexandria, La., has emphasized this, and if the sober expression of opinion against shotgun quarantine and barbaric methods means anything, the old regime is at an end.

The excursion to the Central American ports by a representative body of our Southern citizens has also added a whole chapter of education, and really points the way to effective control of the yellow evil which has so often blown hurtfully this way.

The New Orleans health authorities are actively shaking up the screening ordinance, and very soon every householder will have complied with the law requiring cisterns screened, either under compulsion or at his own volition.

There can be no more such experiences as in the past year, and hereafter New Orleans, Louisiana, and the neighboring States must enjoy immunity from epidemics.

The theory of quarantine is essentially correct, but with its hardships it must give way to the more modern rule of sanitation. Here the law is fulfilled that no breeding can occur where there is no soil for it.

With the beckoning of spring the spirit of hopefulness grows strong, and we are in complete unison with those who wish and work at the same time for a purer, cleaner, and more wholesome city.

Clinical Records.

The House Surgeon of the Charity Hospital in this city, Dr. Batchelor, has recently sent a circular letter to the members of the visiting staff of the Charity Hospital informing them of the adoption of a new system of records for the Hospital. This system is based upon that in vogue at the Bellevue Hospital in New York and has been chosen after careful study of the best that are now in use. It is to be hoped that the members of the visiting staff will give all assistance possible to the Hospital authorities in the proper carrying out of this scheme. The main part, of course, will depend upon the hospital authorities themselves, as the details of the work must devolve upon the internes who are under their immediate jurisdiction.

For several years the Charity Hospital Alumni Association has devoted a good deal of effort in the direction of having the large amount of valuable data at the Charitable Hospital properly collected and recorded. The first step was accomplished when, upon its recommendation, the Board of Administrators decided to create the post of Registrar and imposed the duties of the office upon the Second Assistant House Surgeon. There is no doubt that a modicum of good was accomplished in this manner, but the main purpose, that of having these data available for the use of the profession, and especially of the writers among its number, has been up to now far from accomplishment. System has been lacking as well as a proper realization of the importance of the work. With the new method we hope to see better results and congratulate the management of the Hospital upon the wisdom of their course.

The State Society Meeting.

An appeal is made in this number of The Journal to chairmen of sections to get busy with their program for the May meeting of the Society. Already it is a little late to get to work, as usually several months ahead of the meeting most section work is announced. The early program is a strong inducement to a good discussion, for the member ordinarily is in the habit of selecting the particular field in which he is interested, and usually gives the matter some thought ahead of time.

We have had such successful meetings, however, in the past few years that we anticipate a repetition of these, and The Journal takes this occasion to remind all members of the Society that they are both expected and wanted at New Orleans in May.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In Charge of DR. P. MICHINARD and DR. C. J. MILLER, of New Orleans.

ALBUMINURIA OF PREGNANCY.—Blacker states that there are three main causes for the presence of albumin in the urine in pregnancy: 1, congestion of the kidneys; 2, toxic poisoning; 3, true Bright's disease—the so-called renal albuminuria. Albuminuria occurs in from 1 to 2 per cent. of all cases of pregnancy. The so-called kidney of pregnancy may be due to congestion, pressure, toxæmia, or anæmia. The most constant symptom of the kidney of pregnancy is albuminuria; the amount may vary one-half to one-tenth of the urine examined. Edema of the lower limbs is constantly present, and the patients complain of headache, at first intermittent, later continuous. Failure of vision is frequent, amounting merely to a diminution of sight in most cases. Vomiting is not constant nor usually severe. The kidney of pregnancy exposes the patient to three dangers: Eclampsia, the development of chronic nephritis, and the danger of partial or complete loss of sight. Only a small number of patients develop chronic nephritis (about 6 per cent.) The kidney of pregnancy tends to recur in subsequent pregnancies, mainly when it occurs for the first time in the early months of pregnancy. The prognosis, if properly treated, is decidedly good. If the œdema continues the vision remains impaired, the albumin does not diminish, then the outlook is very grave. If the symptoms remain after the induction of premature labor the patient is likely to develop eclampsia, chronic nephritis, or uræmia.

The treatment is that of acute Bright's disease. A woman suffering from chronic nephritis should be recommended not to marry; or, if they insist, not become pregnant. —*Lancet,* Dec. 25, 1905.

PYELONEPHRITIS IN PREGNANCY AND PUERPERIUM.—Opitz (Ztsch. f. Geburtsh u. Gynäk, Stuttgart) has collected seventy-nine cases and reports five cases from the Marburg klinik. He points out three possible methods of infection bringing about the condition of uretero-pyelo-nephritis—*a,* an ascending infection from the bladder; *b,* infection from the urine itself; *c,* infection by way of the lymph channels. The last is probably the cause of the condition in the puerperium. During pregnancy dilatation of the ureters, especially the right one, is common, and this prevents the usual valve-like communication between the ureter and bladder from acting in such a way as to prevent ascending infection. Opitz believes that the usual obliquity of the uterus to the right side explains the greater frequency of the right ureter being pressed in as it crosses the pelvic brim. The symptoms usually begin about the fifth month, often with rigors, pyrexia, rapid pulse, abdominal pain. The amount of urine is diminished, and contains pus, epithelial cells, and micro organisms. Delivery is usually followed by improvement, which may, however, only be temporary. In twenty-three out of fifty-three cases spontaneous premature birth occurred, and seven out of sixty children were still-born. The treatment recommended is milk diet, urinary disinfectants, and washing the bladder when cystitis is severe. Such treatment failing, the induction of labor, or operation on the affected kidney has to be considered.—*Edinburgh Medical Journal,* January, 1906.

Department of General Medicine.

In Charge of Dr. E. M. Dupaquier, New Orleans.

Creole Immunity.—As is well known, it is the recent arrivals in the endemic area who are most susceptible to yellow fever infection. They are practically, as regards susceptibility, in the same position as the inhabitants of a town where yellow fever is not endemic, but which, from climatic and mosquito conditions, is open to occasional epidemic visitations. In the endemic localities the Creole and the old resident enjoy practical immunity. Why? How has this immunity been acquired? By a mild attack of the disease in childhood, say some. Now if this be the explanation, and if the sanitary authorities have banished yellow fever from Cuba, a generation will grow up there which will be absolutely non-immune as regards the disease. Most surely into this non-immune population virulent yellow fever will be introduced sooner or later, and the end of that island will be worse than the beginning. Then, instead of a few non-immune foreigners to prey on, the yellow fever germ will have the entire population for its victims, and on that day people will think that it would have been better had Reed never been born.

I cannot think, however, that the immunity of the Creole is to be explained on the hypothesis just suggested, namely, mild attacks of ordinary yellow fever in early childhood. For if this were so, then yellow fever would be practically always in evidence in Cuba and similar endemic localities, and the isolation of a few hundred foreigners by mosquito net and other anti-mosquito measures could not have sufficed to stamp out the disease, as it certainly has done. There must be some other explanation for Creole immunity.

As a working hypothesis, I would suggest that there are two strains of yellow fever virus; one of great virulence, one of little virulence. Specifically the same, they are mutually protective. They differ only in their respective pathogenicity. Some such relationship pertains between them as that between small-pox and vaccinia, or as between the singularly mild type of small-pox that has prevailed recently in the West India Islands and elsewhere in the Western Hemisphere, and the more familiar and virulent kind of the disease that has scourged mankind from time immemorial. The native in the endemic area acquires his immunity against the virulent disease from having had the non-virulent disease already.

If this be so, the value of Reed's labor will still hold good, and for all time. It would be enhanced could we ascertain so as to be able to recognize them, the *clinical features of non-virulent yellow fever.* Or, if we could ascertain by what means or process the virus of the virulent disease is robbed of its virulence, or the virus of the non-virulent has its virulence enhanced. I have often speculated, both as regards yellow fever and malaria, as to what may be the effect on the germ by its passage through different species of mosquito, whether one species enhances the virulence, and another species has a contrary effect. The experiments this idea suggests are well worth attempting.

I would suggest, therefore, as subjects for investigation: First, the clinical marks of non-virulent yellow fever in the Creole in the endemic area of the disease. Second, the influence of species of transmitting mosquito on the virulence of the germs of yellow fever and malaria. [Sir Patrick Manson, *Lectures on Tropical Diseases,* being The Lane Lectures for 1905, delivered at Cooper Medical College, San Francisco, U. S. A., August, 1905, page 210, *Problems in Tropical Medicine.*]

Department of Therapeutics and Pharmacology.

In Charge of Dr. J. A. Storck and Dr. J. T. Halsey, New Orleans.

Sodium Citrate in Vomiting of Infancy—Variot is quoted as favoring the use of small quantities of this salt in the milk which is administered. The calcium salts are precipitated and the coagulum of the milk is rendered less resistant. A 1% solution of the sodium citrate is employed, and of this one teaspoonful is the dose, given just before feeding.—*Policlinico* (Rome)—*American Medicine.*

Cardiac Asthma.—A patient with aortic insufficiency in the stage of compensation rarely suffers from shortness of breath unless he exerts himself immoderately, and even then the dyspnea lasts only a short time; this is due to the muscle of the left ventricle being strong enough to empty the blood from its cavity and the pulmonary circulation is therefore kept undisturbed. In mitral stenosis, dyspnea exists always at the slightest exertion, as the better the right ventricle compensates, the fuller the vessels of the lesser circulation will be; on this account the patient will always be more or less cyanosed. In uncomplicated cases of arteriosclerosis the condition is just as in aortic insufficiency. Asthma in these cases will usually be sudden and unexpected. A. Fränkel describes an attack thus: It comes on with or without mental or physical exertion, sometimes in the midst of sleep. The patient to be able to breathe must get himself in the sitting or standing posture; associated with this is a sensation of tightness, cyanosis, coldness of extremities, scanty expectoration and numerous audible pulmonary rales; rarely there is pain. This lasts from ten minutes to several hours, when the patient will fall into the sleep of exhaustion. The pulse depending on the condition of the heart, will be full and rhythmic, full and irregular, or lastly weak and irregular. The attacks recur frequently and become accompanied by hepatic congestion, oliguria, albumin and general edema. The pathologic cause of cardiac asthma is to be found in diminished elasticity of the bronchial tree. But it depends upon the strength and nutrition of the left ventricle, whether or not these attacks will occur, and therefore arteriosclerosis, in which the coronary vessels are not affected, remain free from these attacks longer than individuals with aortic insufficiency, in whom the left ventricle is exposed to inordinate pressure both in systole and diastole. Cardiac asthma is to be differentiated from gastric asthma, which arises reflexly and is characterized by tachycardia, gastric symptoms, and a history of injudicious eating; aneurysmal asthma, in which the stenosed part of the trachea is the seat of sudden swelling of the mucous membrane and in which tracheal stridor is noted; bronchial asthma, in which expiratory dyspnea is present. If tension is very great, frequently repeated venesections or wet cuppings are indicated; only enough blood should be withdrawn to relieve pulmonary congestion; in very bad cases digitalis, strophantus, caffein and morphin are indicated; in first attacks the improvement will be greater and quicker than in later paroxysms. The combination used by him is:

Powdered digitalis leaves, 1.5 gm. (22½ gr.)
Caffein and sodium benzoate, 3 grm. (45 gr.)
Powdered rhubarb root } *q. s.*
Extract of gentian }
To be made into 30 pills.

He orders 2 pills three times daily for 5 days, 2 pills twice daily for 10 days, and 1 pill twice daily for 10 days. For the attack itself he gives a hypodermic injection of morphin 0.01 gm. to 0.015 gm. (7½ gr. to ¼ gr.), which usually gives almost instantaneous relief; oxygen inhalations, oxaphor (alcoholic oxygen, camphor solution), 15 to 20 drops several times daily in wine is also useful. Heroin, chloral and other hypnotics may also have to be used. (*Deutsche Medicinische Wochenschrift,* 1905, xxx, 569.)—*American Medicine.*

Department of Nervous and Mental Diseases.

In Charge of Dr. P. E. Archinard and Dr. Roy M. Van Wart,
New Orleans.

A Story of the Larynx in Tabes.—Greene (*Boston Medical and Surgical Journal,* Vol. CLIV, No. 4) studied the larynx in 60 cases of tabes. Of these, 9 or 15 per cent showed laryngeal complications; 6 or 10 per cent showed paralysis of one or both vocal cords; 7 or 12 per cent. were affected with laryngeal crises, three without evident paralysis of either cord; and one showed a jerky movement of the cord in moving from the median line. The paralysis was an abductor paralysis in all cases. Five of the six cases were unilateral and one was bilateral; three were complete and three partial.

He refers to Grabower's studies to explain the frequency of the abductor paralysis. The posterior crico-arytenoid muscle receives relatively fewer nerve fibres than the other muscles and as there is a slow progressive degeneration in the recurrent laryngeal nerve it is easy to understand why the abductor first succumbs.

In none of the cases examined did I detect disturbance of sensation (anesthesia or hyperesthesia) sufficient to classify it outside of the normal limits.

The crises and paralysis occur early in the disease and may lead, as in two of the writer's cases, to a diagnosis of the nervous condition. The paralysis of unilateral type may exist for a period of time undetected.

The writer concludes that from the laryngologist's standpoint "that tabes as an etiological factor, either in vocal cord paralysis or spasmodic laryngeal cough, should never be overlooked."

Brain Abscess.—Hammond (*Ibid.*) reports a case with recovery following operation. The operative treatment is not very successful. Of nineteen cases operated on at the Massachusetts Charitable Eye and Ear Infirmary, two recovered. The patient was a laborer, *aet.* 41, and presented himself at the clinic for the relief of earache. He had had a discharge from the ear for six weeks about a year previous. There had been severe pain in the right ear during the last seven days, but no discharge. There had been mastoid tenderness for two days, but no vomiting, dizziness or chills.

The right drum membrane was swollen and bulging, but there was no perforation. It was incised and the ear douched and the patient put to bed.

Two days later the patient was found unconscious on the floor. When seen after the fall he had labored breathing and a slow pulse, and complained of severe pain in the head. He vomited several times during the night and complained of feeling dizzy. The following day the pupils were equal, contracted to pin-point size and reacted sluggishly to light and distance. The reflexes were equal. There was a foul discharge from the ear. The fundi were normal.

Operation under ether on removal of the mastoid tegmen allowed the escape of a quantity of foul pus and brain substance. The cavity was packed with gauze and the patient made a good recovery.

CEREBELLAR ABSCESS.—Ciampiolini reports a case of cerebellar abscess following otitis media (*Clin. Med.,* July 19, 1905; Ref. *British Medical Journal*) which occurred in a child of 10 years. He had suffered from infancy from a chronic otorrhea. Suddenly, after a severe pain, he had an abundant purulent discharge from the meatus, accompanied by rigor, fever, occipital headache, vomiting and vertigo. He was admitted to hospital for immediate operation. A quantity of pus was evacuated. the bone was found to be eroded and the mastoid cells full of pus and débris. After the operation the temperature fell; although it rose at night and for some days there was no recurrence of the vomiting and vertigo and the boy was shortly able to be up and about. On the 23rd day a recurrence of headache and rigors, with a rise in temperature, made operation necessary. The surgeon exposed the meninges over the middle cerebral fossa but was prevented from examining the plugging of that part of the cavity. He explored the labyrinth but did not find the abscess. Two days later he incised the dura mater over the middle cerebral fossa, when some clear, yellow fluid escaped. The patient continued to suffer from headache and vertigo, with vomiting and optical disturbance. A subsequent operation was undertaken and a quantity of creamy, yellow pus was found in the cerebellum. The cavity, which occupied almost the whole of the right lobe of the cerebellum, was packed with iodoform gauze. The symptoms did not abate, and he died on the 45th day of a profuse purulent meningitis. The autopsy showed the destruction of the right lobe of the cerebellum, with the diffuse purulent meningitis.

Department of Ear, Nose and Throat.

In Charge of A. W. Roaldes, M. D., and Gordon King, M. D., New Orleans.

Chloride of Sodium in the Treatment of Chronic Pharyngitis.—Some most interesting observations have been recently made by C. Chauveau in regard to the influence of the chlorides on the condition of the pharyngeal and nasal mucous membranes. This author noted the fact that certain forms of chronic pharyngitis characterized by dryness of the mucous membrane and lack of normal secretion were accompanied by a deficient quantity of sodium chloride in the urine. In contrast to this, he observed that cases of pharyngitis of the type known as hypertrophic, with hypersecretion and congestion, were associated with an excessive quantity of chloride in the urine. The former class of cases is found to be greatly benefited and even cured by subjecting the patient to a salty diet and the local application of sodium chloride. In the latter type equally good results are obtained by prohibiting the use of salty food, and thereby diminishing the excretion of salines in the urine. The author substantiates his claims for this method of treatment by a series of clinical cases in which excellent results were obtained without other additional treatment. The forms of pharyngitis thus treated are very rebellious to the usual methods in use and the dietary regime should always be at least given due attention. Mention is also made of atrophic rhinitis being favorably modified by the same treatment.

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist., Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

Important Notice to Parish Secretaries.—The Treasurer desires to call the attention of the secretaries and treasurers of parish societies to the amendment to the constitution and by-laws which requires that settlements be made thirty days prior to the meeting of the state society. As April 8 is the limit this year, under this provision, they are earnestly requested to make their collections and remittances before that day.

Election of Officers.—Iberville Parish Medical Society met on January 16, 1906, and elected the following officers: President, Dr. W. E. Barker, of Plaquemine; Vice-President, Dr. S. L. Singletary, of Grosse Tete; Secretary-Treasurer, Dr. B. O. LeBlanc, St. Gabriel.

Jackson Parish Organized.—Jackson Parish Medical Society was organized on January 19, 1906, with eight members, as follows: Dr. Ml. B. Culpepper, Hood's Mill, President; Dr. G. E. Cannon, Jonesboro, Vice-President; Dr. J. A. Gaar, Jonesboro, Secretary; Dr. I. M. George, Jonesboro, Treasurer; Drs. Robert P. Jeffries, Jonesboro; J. H. Landrum, Eros; M. M. Hearn, Eros; Charles A. Evans, Hodge. The society was chartered by this office January 29, 1906.

Assumption Parish Medical Society.—A special meeting of the Assumption Parish Medical Society was held at Napoleonville on February 10, 1906, for the purpose of naming delegates to the Alexandria Health Conference. A large attendance bore testimony to the interest taken by the members in sanitary matters. The following were appointed delegates: Drs. Fulton Rogers, A. A. Aucoin and W. E. Kittredge.

Bienville Parish Medical Society.—The Bienville Parish Medical Society met in annual session at Gibsland, January 9, 1906, President A. J. Pennington in the chair. Secretary-Treasurer A. B. Nelson read his report, showing a balance on hand of $19.70. On motion of Dr. Thornhill, a committee was appointed to draft resolutions requesting Representative J. Rush Wimberly to support the bill regulating the practice of medicine in this State. Drs. Thornhill, Hamner and Smith were named on the committee.

The election of officers was then proceeded with, as follows: President, Dr. J. Atkinson, Arcadia; Vice-President, Dr. O. O. Hamner, Bienville; Secretary-Treasurer, Dr. H. L. Smith, Gibsland.

Drs. J. N. Blume and R. C. Ferguson were elected members.

Dr. Thornhill read an excellent paper on "Medical Ethics," after which the Society adjourned until 2 p. m., at which time the Committee on Resolutions read the following report:

"Recognizing the necessity for legislation to protect the public against incompetent practitioners of medicine, and for the better enforcement of the law regulating the practice of medicine, and,

"Whereas, There will probably be a bill introduced at the next session of the Legislature, amending the present medical law, so as to change it from a civil process to a criminal statute; therefore, be it

"Resolved, by the Bienville Parish Medical Society now in session, That our Representative, the Hon. J. Rush Wimberly, be requested to lend his influence in securing the passage of the bill.

"Resolved, further, That a copy of the resolutions be served on the Hon. J. Rush Wimberly, before the assembling of the next Legislature.

"Resolved further, That the President of the Bienville Parish Medical Society, appoint a committee of one to go to Baton Rouge on the assembling of the Legislature to aid in securing the passage of the bill."

The report of the committee was adopted, and Dr. Thornhill appointed delegate by the President.

Dr. Hamner then read a very interesting paper "on "Differential Diagnosis and Treatment of the More Common Diseases of the Eye, Met with by the General Practitioner."

Discussion was opened by Dr. Thornhill.

This was followed by a "History of Pneumonia for last Fifty Years," by Dr. Smith.

Discussion opened by Dr. Wilson.

As the time for adjournment had arrived, Dr. Nelson's paper on "Diagnosis and Treatment of Gall Stones," was continued, and after the report of the Committee on Program for next meeting, the society adjourned.

What a County Society May Do.—The following letter from one of the leading surgeons of Indiana contains so much of interest to county societies, indicating what may be done in any section where as many as three or four wide-awake men can be gotten together, that we are glad to put it before the profession. "What one man has done, other men can do."

Valparaiso, Ind., December 21, 1905.

Dr. J. N. McCormack, Chairman Committee on Organization,
Bowling Green, Ky.

Dear Doctor: Your letter asking me to elaborate our plan of post graduate work here, with the view that such an account may be used in inducing other medical societies to do likewise, has been re-which would broaden him as a physician. With this end in view, we sincerely yours. David J. Loring, M. D.

I am greatly pleased to have the privilege to do this, not only for your personal gratification, but for the reason that I am confident that it will redound to the very great benefit of such societies as deem it wise to adopt our plan, as well as to the individual members. It will enable them to do better and more efficient work for the public as a whole, and aid each individual physician in rendering the best possible service to the unfortunate sick.

Our work was begun two years ago by getting every physician interested in becoming more familiar with scientific and practical knowledge which would be an advantage to him at the bedside, and which would braden him as a physician. With this end in view, we rented a room, formed a club, and endeavored in every way to appeal to and build up the social, scientific, and material spirit and welfare of the profession. From every point of view I desire to report that we have been eminently successful.

In carrying out this plan we divided our work in such a way that each physician was required to act as a teacher of some special subject, and all the others took their places as students once more. Anatomy and Surgery were assigned to one, Physiology and Practice to another, and so on through the list of subjects, one fundamental and one practical branch to each teacher. Our meetings were held twice a week, regular lessons were assigned, and we were expected to be present and give one hour's time to the recitation and study of such subjects as were assigned to that evening. In this way we were enabled not only to exchange individual views as to what we believed, but could always have some good medical authority to place us right if it was found that we were wrong. This plan proved very desirable and we soon learned that the teacher of the topic derived far greater benefit from his course, for the reason that he was required to study more to hold his ground, often against the combined opinion of his class.

After going along in this way for a time, it became apparent that our faculty should be changed from time to time, in order that the teachers should become proficient in more than one subject. I desire to report to you that we found this most satisfactory, and that it has resulted in a marked improvement in the attainments of every member of our profession, which means, of course, of the profession as a whole.

The social feature of our plan has done as much, if not more, for the good of the profession, as the scientific work. I am now able to say that we have no one in this county not on the most friendly terms with each other, and that such condition is because they actually desire to be friendly.

In addition, we have kept up our regular society meetings, always with increased interest, and although ours is not one of the large counties, I feel safe in saying that we have one of the best, if not the best, societies in the State of Indiana, and we are resolved to go on and make it still better.

In connection with this work it did not take us long to determine that, in consideration of the increase in the cost of living in recent years, we were not being adequately paid for our services, and we concluded that it was only just that the scale of fees should be increased one-half. In order that this might be uniform, we all signed the schedule definitely fixing the price of services for both day and night, and had this published. It went into effect without a single ripple, and has been strictly maintained. I have never heard a complaint on the part of the public or of the agreement being violated by any member. In fact, the public seem to understand the necessity for the change, largely for the reason that it knew we were making an heroic effort to give the people better service. The results have been that our incomes have been increased by one-half, and that night work has been reduced to a minimum, giving us the evenings for post graduate work and to spend with our families. While we have not accomplished all that we set out to do, we have certainly made rapid progress, and are not to stop or falter until our ideals are attained.

Probably this very crude plan might be greatly elaborated and improved, but it has worked so well, and given such universal satisfaction here that I am sure none of us would be willing to disturb our present satisfactory condition.

Should you be able to use what we have done as an incentive for others, or to elaborate it for the promotion of medical organization, you will have the very best wishes of every member of our profession in doing so. With personal best wishes, I am, most sincerely yours,

DAVID J. LORING, M. D.

THE MEETING.—Members are reminded that the Annual Meeting of Louisiana State Medical Society will take place on May 8, 9 and 10, 1906, at New Orleans. Active steps are being taken to make this a successful and interesting session, and those who have not already done so are requested to send in titles of their papers at once.

Full particulars of the program and the report of the Committee on Arrangement outlining what has thus far been accomplished, and giving all necessary details, will be published in the next issue of THE JOURNAL.

CHAIRMEN OF SECTIONS ARE EARNESTLY REQUESTED TO SEND IN THEIR TITLES AT ONCE.

Medical News Items.

ROCKEFELLER INSTITUTE SCHOLARSHIPS AND FELLOWSHIPS.—The Rockefeller Institute for Medical Research purposes to award for the year 1906-07 a limited number of scholarships and fellowships for work to be carried on in the laboratories of the Institute in New York City, under the following conditions: The scholarships and fellowships will be granted to assist investigations in experimental pathology, bacteriology, medical zoölogy, physiology, pharmacology, and physiological and pathological chemistry. They are open to men and women who are properly qualified to undertake research work in any of the above mentioned subjects and are granted for one year. The value of these scholarships and fellowships ranges from six hundred to one thousand dollars. It is expected that holders of the scholarships and fellowships will devote their entire time to research. Applications, accompanied by proper credentials, should be in the hands of the Secretary of the Rockefeller Institute, Dr. L. Emmett Holt, 14 West Fifty-fifth Street, New York City, not later than April 1, 1906.—*Exch.*

THE "LOCKWOOD" BILL.—The drug bill known as the "Lockwood" bill was practically killed by action of the House Committee on Health and Quarantine at Jackson, Miss., in voting unanimously to report the bill adversely. This bill provides that all patent and proprietary medicines shall be labeled to show the exact formula of the contents, thus publishing the secret of their preparation to the world. The bill has been strongly opposed by druggists of the State, who argue that it compels them to give away their secret formulas and thus prevents them from getting the legitimate profits on discoveries made in years of practice and experience in combining drugs.

CONVICTION OF A MENTAL HEALER.—After a trial of about twelve days, a very notorious self-styled mental healer, who had conducted a flourishing "Mental Science Institute" at Sea Breeze, Fla., was found guilty in a United States Court at Jacksonville, on February 3, and sentenced to a pay a fine of $500 and serve thirty days in jail.

DIRECTORY OF THE DOCTORS OF IOWA.—The January number of the *Iowa Medical Journal* contains a complete directory of the doctors of Iowa which has been prepared at a considerable expenditure of time, and with great care, with a view to making it of practical value to the entire profession of the State.

THE INTERSTATE MEDICAL JOURNAL OF ST. LOUIS, in its January issue gives a review of the medical literature of the past year. It is a fine number and its publishers are to be congratulated.

DEATHS AND BIRTHS IN ILLINOIS DURING 1905.—In Illinois last year there were 65,000 deaths and 150,000 births. The males born exceeded the females by about 6,000.

THE CITY COUNCIL OF NEW IBERIA, LA., in regular meeting assembled, adopted resolutions providing for the screening of cisterns and other receptacles of water, to take effect March 15.

THE CITY BOARD OF HEALTH OF LAKE CHARLES at its last meeting passed a resolution declaring the position of garbage contractor vacant and the Secretary was instructed to advertise for bids for cleaning the city and keeping it clean. The screening of cisterns will be enforced.

NATCHEZ, MISS., has passed an anti-mosquito ordinance as a preventive of yellow fever.

THE STATE BOARD OF PHARMACY held an examination on February 2 and 3 and there were eight passed.

AT THE LAST MEETING OF THE IBERVILLE PARISH MEDICAL SOCIETY, Dr. M. E. Bander was elected President. After the meeting the Society was entertained at the Enterprise Hotel by the local professional of Whitecastle.

PERSONALS: Dr. T. F. Richardson, P. A. S., M. H. & P. H. Service, excused from duty, without pay, from April 30, 1906, to February 15, 1907, for the purpose of undertaking the sanitation of the north coast of the Republic of Honduras.

Dr. J. R. Rathmell has been elected Dean of Chattanooga Medical College, to fill the place of Dr. E. A. Cobleigh, deceased.

Dr. C. M. Menville, of Houma, has been appointed coroner of that town in place of Dr. C. A. Duval, deceased.

Drs. H. P. Jones and P. J. Gelpi have been appointed on the Committee of Health and Quarantine by the Progressive Union.

Dr. P. F. Points and Dr. J. W. Groetsch were elected by the School Board as Medical Inspectors, to investigate the question of vaccination in the local schools.

Dr. Henry R. Slack, Superintendent of La Grange Sanatorium, at La Grange, Ga., has sent the JOURNAL a circular about the attractiveness of his institution.

Dr. Allen Jumel returned recently, after an absence of nine months spent in Bocas del Toro, Panama, where he has been stationed.

REMOVALS: Dr. W. P. Cooksey has moved from Homer, La., to Atlanta, Ark. Dr. C. C. Clark has moved from Mer Rouge, La., to Merrillton, Ark.; Dr. C. P. Gray from Cheniere, La., to West Monroe; Dr. F. Vidrine from Cataro, La., to Andreport.

RECENT VISITORS TO NEW ORLEANS: Dr. F. R. Bernard, of Lake Providence; Dr. L. H. Jastremski, of Houma, La.; Dr. B. B. Reynaud, of Baton Rouge, La.

MARRIED: On February 13, at Hermanville, Miss., Dr. A. L. Chapman to Miss Bertha M. Clark.

DIED: Claiborne Alexander Duval, Sr., died at his residence in Houma, La. Dr. Duval was a Confederate surgeon during the Civil War and served until the surrender. He has filled the position of coroner and health official in Houma, which position he filled with great zeal and carefulness.

Dr. N. D. Young, of Youngsville, La., died on February 8, at the age of 64.

Dr. Wm. Gaines Kibbe, of Abbeville, La., died suddenly of apoplexy in his office, aged sixty-four. Dr. Kibbe was the father of Dr. C. W. Kibbe, of Abbeville, and Dr. J. E. Kibbe, of Erath, La.

Dr. W. D. Norwood, of Shreveport, La., was killed on February 13 by being thrown from his carriage. Dr. Norwood was a native of Marshall, Tex., and was about 35 years of age.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Practical Massage in Twenty Lessons, by HARTVIG NISSEN. F. A. Davis Company, 1905.

There is a good deal in massage as regards the help we can give in many cases. It is useless for the physician to depend on an expert "masseur" or "masseuse." He should know how to perform "massage" and perform it himself. There is a field open to many. This book is the result of the author's life's work, thirty years of experience as a masseur, and for several years teacher of massage at Harvard University Summer School. It is a combination of "manipulations" and "movements," well exposed in this little book of great practical value. E. M. D.

Dayton's Epitome of the Practice of Medicine.

A manual for students and practitioners, one of Lea's series of Medical Epitomes, edited by VICTOR C. PEDERSON, M. D. A wonderfully comprehensive little book containing an astonishing amount of accurate information. E. M. D.

Radasch's Compend of Histology with ninety-eight illustrations. One of Blakiston's quiz-compends, which are known as one of the best series of manuals for the use of students. It presents the subject in as attractive a manner as possible, information being collected in a condensed practical shape, fitting the wants of students. E. M. D.

Progressive Medicine, September 1, 1905.

This volume, No. 3, for 1905, reviews the diseases of the thorax and its viscera, including the heart, lungs and blood vessels, of the skin and syphilis, of the nervous system and finally considers obstetrics. The usual carefully made index ends this volume which, like its fellows, is a model. E. M. D.

The Medical Diseases of Egypt, by F. M. SANDURTH, M. D., F. R. C. P., consulting physician to H. H., the Khedive and to Kasr-el-ainy Hospital, Cairo, etc. Published by Henry Kempton, London, 1905.

This is part 1 of a work which promises to be a modern successor to that of Pruner and Guesenger, the well-known German authorities on Egyptian diseases. A peculiar flavor attaches to this subject besides the general attraction exotic or rather diseases of all tropical and semi-tropical regions now have for readers among the profession and laity. Manson, with his great authority, deplores the fact that so many young physicians are sent to treat diseases in certain regions with which they are not at all familiar and he puts it down as a criminal act. No one would gainsay the truth of the remark. Sandurth thought of the needs of that class of men in writing his book, a very interesting book, indeed. Rapid transit makes close neighbors of us all and many infections of a remote land will be imported and brought to our very doors, when we least expect it. All that is human is of interest to every one of us, anyway, and it is quite a number of years that Publius Terentius Afer, a Roman comic poet (155 years before Christ), said so. Manson in his latest statements on tropical problems predicts that our latest enterprise, the Panama canal, will open the way of the Pacific traffic to yellow fever. We pity the Asiatics beforehand and feel encouraged to work so as to avoid such a calamity, a generous return for Asiatic plague and cholera brought to our shores.

E. M. D.

The Principles and Practice of Medicine, by WILLIAM OSLER. Sixth edition. D. Appleton & Company, 1905.

Osler's work appears in a new dress and much more amplified, yet from the arrangement of a larger page and new type, the volume retains its usual size. This edition presents a new book, and so far there is no reason why its reputation of being an excellent text-book should be at all questioned this time as ever before. Yet, it is regrettable to see imperfections in important places; for instance, if we are good judges, that which refers to treatment in yellow fever. It starts by stating that nursing gives the best results, and then follows a string of drugs, the value of every one of which is *questionable,* therefore useless to be recommended or even cited before those who do not know any better. E. M. D.

Publications Received.

Lea Bros. & Co., Philadelphia and New York, 1906.

A Text-Book of Pharmacology and Therapeutics, by Arthur R. Cushny, M. A., M. D. 4th edition.

Anatomy, Descriptive and Surgical, by Henry Gray, M. D. Edited by Pickhowden. Revised and re-edited by John Chalmers DaCosta, M. D.

The Diseases of Infancy and Childhood, by Henry Koplik, M. D.

Thornton's Pocket Formulary.

W. T. Keener & Co., Chicago, 1905.

Lectures on Tropical Diseases, Being the Lane Lectures for 1905, by Sir Patrick Manson.

P. Blakiston's Son & Co., Philadelphia, 1906.

The Practice of Medicine, by James Tyson, M. D.

Surgical Treatment of Chronic Suppuration of the Middle Ear and Mastoid, by Seymour Oppenheimer, M. D.

Materia Medica, Pharmacy and Therapeutics, by Sam'l O. L. Potter, A. M., M. D. 10th edition. Revised.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

For January, 1906.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	3	1	4
Intermittent Fever (Malarial Cachexia)	2	2	4
Smallpox			
Measles			
Scarlet Fever			
Whooping Cough			
Diphtheria and Croup	4		4
Influenza	14	7	21
Cholera Nostras			
Pyemia and Septicemia			
Tuberculosis	45	34	79
Cancer	24	4	28
Rheumatism and Gout	1	1	2
Diabetes	1	1	2
Alcoholism	1		1
Encephalitis and Meningitis	7	1	8
Locomotor Ataxia	1	1	2
Congestion, Hemorrhage and Softening of Brain	15	5	20
Paralysis	2	2	4
Convulsions of Infants		2	2
Other Diseases of Infancy	14	3	17
Tetanus	1	4	5
Other Nervous Diseases	1		1
Heart Diseases	61	31	92
Bronchitis	4	4	8
Pneumonia and Broncho-Pneumonia	38	27	65
Other Respiratory Diseases	7	2	9
Ulcer of Stomach	1		1
Other Diseases of the Stomach	2		2
Diarrhea, Dysentery and Enteritis	14	7	21
Hernia, Intestinal Obstruction	5	1	6
Cirrhosis of Liver	6	1	7
Other Diseases of the Liver	2	1	3
Simple Peritonitis	1	2	3
Appendicitis	3	1	4
Bright's Disease	34	23	57
Other Genito-Urinary Diseases	4	6	10
Puerperal Diseases	3	3	6
Senile Debility	22	9	31
Suicide	6		6
Injuries	25	18	43
All Other Causes	13	6	19
TOTAL	387	210	597

Still-born Children—White, 23; colored, 18; total, 41.

Population of City (estimated)—White, 245,000; colored, 88,000; total, 333,000.

Death Rate per 1000 per annum for Month—White, 18.54; colored, 28.63; total, 21.51.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	30.14
Mean temperature	54.
Total precipitation	14.43 inches.

Prevailing direction of wind, northwest.

New Orleans Medical and Surgical Journal.

VOL. LVIII. APRIL, 1906. No. 10

Clinical Report.

A Case of Black Water Fever.

By E. DUNBAR NEWELL, B. S., M. D., St. Joseph, La.

A. B. White, male, age 14, well developed, hardy and active but has never had, during the six years that I have known him, a robust or ruddy complexion, has always appeared a little anemic. During the last six years I have treated, at various times, all the members of the family for malaria, and his brother and sister for pernicious malaria—the brother for acute malarial congestion with large hemorrhages from bowels, and the sister for hemoglobinuria. The brother's case I reported at the last meeting of the State Medical Society.

On November 19, 20 and 21 he had distinct chills in the morning followed by light fever, and several other times during the summer he had "chills and fevers." The night of the 20th he took one 4-grain capsule of quinin sulphate and the same on the morning of the 21st. He got up as usual that morning and drove to school, and while in school had a very hard chill. I saw him at 2 p. m.; his temperature was 103½, pulse 120, very pale, and both liver and spleen enlarged, but not markedly so. He was not cyanosed or congested and was bright and lively and said he felt very well. At 6 p. m. he passed a large quantity of black urine, and was restless, nervous and uneasy. During the next twenty-four hours he passed this black urine very freely and very often—fully three times the normal quantity of urine. During the next twenty-four hours it gradually became lighter in color, until, ninety-six hours after first black passage, the color was about normal.

Temperature during this time ranged from 102 in morning to 103½ at night; pulse from 120-145, very soft and weak; liver dulness two inches longer than normal; spleen enormously enlarged, hard and tender; patient could not lie on left side; conjunctiva bloodless and jaundiced; gums very soft; stomach congested, very tender on pressure, easily nauseated; patient very restless and tossing about the bed constantly; face pale, yellow, pinched and anxious.

For twenty-four hours color black, 20% moist albumin, but no blood corpuscles; after forty-eight hours urine about normal in color, 5% moist albumin, large quantities of urates and phosphates.

BLOOD.

Drew blood on 23d and stained with Wright's stain, and after repeated examinations did not find any malarial parasites. Examined it several times afterwards with the same result. I sent some of the same blood to Prof. Halsey of Tulane University, and his reports are below:

"First specimen (Wright's stain):

"Marked inequality in size of cells, some inequality in shape of cells. Many unequal cysts and a good many microcysts. Marked polychromatophilia. A number of normoblasts.

"Second specimen: General characteristics of blood similar to above.

"Second specimen, differential count:

Polymorphonuclear	142	47.3%	
Small lymphocites	96	32 %	45.3%
Large lymphocites	26	8.6%	
Transitional	14	4.7%	
Eosinophiles	19	6.3%	
Mast cells	3	1.0%	
	300	99.94%	

"Seven normoblasts seen in counting 300 leucocytes."

A third specimen sent to Prof. Halsey in January, after patient was up and around, Prof. Halsey reports on as follows:

"Moderate anisocytosis, but no very large or very small cells; no poikilocytosis; no polychromatophiles; no nucelated reds and no malarial parasites. Differential count of 400 leucocytes shows:

Polymorph	29.5
Small lymph	36.5
Large lymph	24.5
Transitional	5.0
Eosinophiles	4.0
Mast cells	0.5
	100.00

Dr. Halsey makes the following comment on the above reports:

"I have found no malarial parasites in spite of having looked for hours to find them. There were a few (about 10 or 12) red cells in which there were seen something suggesting irregular or ring shaped, faintly staining (blue) bodies. The appearance of such cells certainly suggests that these substances might be parasites, but I feel confident that they could not be malarial parasites such as have already been described. I am strongly of the belief that in your case, which had, I understand, fever when the slides were taken, such examination as has been made by yourself and myself would have shown us the malarial organism had the fever been due to the malarial parasites. The above-mentioned bodies are not clear enough or numerous enough for me to believe that they have necessarily any significance. They may be artefarcts."

Patient was confined to bed from November 21 to December 3, and fever lasted until December 7. However, the last week the temperature ran very low.

TREATMENT.

Calomel was given at once, and several times afterwards, and always followed with magnesium sulphate. Twenty drops of solution adrenalin chloride was given every 3 hours for 48 hours to control hemorrhage. Five drops Fowler's Solution and 10 of tr.

nux vomica were given every 3 hours until December 2—ten days after first black passage—when the following prescription was substituted:

℞

Strychnin sulp.	gr. 1-5.
Arsenious acid	gr. 1-5.
Quinin bisulphate	gr. xii.
Reduced iron	gr. xii.
Podophyllin resin	gr. i.

Caps. No. 12.

Sig: One three times a day.

He was made to drink Celestin vichy very freely from the beginning to the end of the attack.

NOURISHMENT.

No food was given for first 48 hours, and after that only strictly liquid diet at regular intervals.

CONCLUSION.

I have never seen this form of malaria follow or accompany the æstivo-antumnal fevers. I have had cases that were not preceded by either chills or fevers, but the fever would always develop a few hours after first black passage.

If these cases are treated about in the same way that we treat yellow fever—and of course without any quinin of any kind—they nearly always recover.

Louisiana State Medical Society Proceedings.

(EDITED BY PUBLICATION COMMITTEE).
P. L. Thibaut, M. D., Chairman.

The Doctor's Salary.

By E. DUNBAR NEWELL, St. Joseph, La.

I was actuated to write this paper in order to bring out clearly before the medical profession its place in the financial world and to keep ever before us the necessity of upholding our legitimate prices. The laity have no idea of the poor salaries that the great majority of the doctors receive. Such expressions as the following indicate their feelings and show their ignorance on this subject: "Don't the doctors make lots of money;" "All of the doctors are getting rich;" "I wish I could make money easy like the doctors;" "$2 for showing your tongue;" "$25 for one call." Doctors have heard these expressions of opinion so often that they frequently forget, themselves, the utter fallacy of such aphorisms. Before going into the details of the doctor's salary I must say that my statements refer principally to doctors who live in the alluvial country sections and small towns of Louisiana.

We can best judge the doctor's pay by comparing it with the pay of other professional men, artisans, traders, laborers, merchants and farmers. Before a medical student is allowed to matriculate in any of the reputable medical schools, he must show a certificate of good moral standing, and must either be a graduate of a college or university or must have received at least a high school education. The great majority of reputable physicians have taken two years at college or university (many are graduates), besides the four years at a medical school. We will not credit the doctor with his high-school education, as nearly all of his competitors have had that, but we will credit his account with two years at college or university, and his four years of compulsion at his medical "alma mater." The two years of college or university life will cost him $600 and the four years of medical school life $2,000. Averaging the interest on this for six years will be about equal to the interest on $2,600 for three years, which at 8 per cent. interest will be $624. His first equipment of books, instruments, horses, buggy, etc., will be $500. While the medical student has been spending this $2,600, and losing interest, preparing himself for his professional life, his competitor, who graduated at the high school with him, has been working for a salary for six years and receiving compensation and advancement from year to year. If he has been near so industrious and hard worked as his competitor in the medical school he will have saved $1,000 during these six years, and have gained valuable business knowledge and a compensation, which with his judiciously invested savings will increase from year to year, and when he has been in business thirty years he will most probably be rated as a wealthy man, with a life before him of idleness and pleasure if he desires.

According to our figures the young doctor has a cash capitalization of $2,600 in education, $624 interest that could have been earned, and $500 in first equipment, or a total of $3,724 which if invested in a business enterprise backed with brains and energy should entitle its investor to a salary of $1,000 the first year, $1,500 the second year, $2,000 the third year, until the tenth year of business he should be netting $5,000 a year.

A merchant or planter with $3,724 invested and all of his energy and untiring watchfulness concentrated on that investment, would be considered unsuccessful if he was not earning $5,000 a year at the end of the ten years of saving and hard toil.

The young doctor has $3,224 put in capitalizing his brain, $500 in his first equipment and six years of daily toil capitalized in acuteness of touch, acuteness of observation and diagnosis, a steadiness of nerves and feelings, and ability to act quickly and surely without excitement or commotion. These are but a few of the attainments of long years of work.

What is his pay for his first year's work? First year $1,500 to $2,000, gross collections; second year, $2,000 to $2,500; third year, $2,500 to $3,000; fourth year, $3,500 to $4,000, which is about as high as he can expect to go, as there are very, very few physicians in the smaller towns and in country locations who make $5,000 a year.

In the large cities the young practitioner usually makes just enough to subsist on for the first three years of practice, and it takes many years of practice to earn a salary of $5,000. The ten, fifteen and twenty thousand-dollar salaries are earned only by the few genius-gifted diagnosticians and brilliant surgeons, and then only after years of hard, faithful toil.

None ever become wealthy, as the word is now defined, from the practice of medicine alone. I do not believe that there is a physician in the South who is worth a million dollars who has earned it entirely by the practice of medicine or surgery. We can find millionaires in every other field of occupation in the South except among the doctors, but these are the men "who make money so fast," according to the popular misunderstanding.

When we speak of the doctor's yearly income, we mean gross cash collections—those vast myriads of uncollected accounts that have cost so many silent outbursts of temper we will not disturb. From this we will deduct the extra costs that are not incident to the occupations of his competitors, but which are necessary expenses for the doctor. Books and journals, $50 to $100 a year; instruments, $50 to $100 a year, according to extent of practice; medicines which are usually furnished in the country, $150 to $500 a year according to income; horses and buggies cost from $75 to $350 a year; driver to attend him from $150 to $180 a year.

The doctor's position in the community demands that he dress and live in harmony with the regard and expectation of his patients: "A thing to be respected must be respectable."

The doctor who has a total yearly cash collection of $1,000 must spend at least $400 a year entirely as an expense to his practice, and the doctor who has a salary of $5,000 a year must spend in the same way $1,000 to $1,500 to attain this fee and to continue his skill and education. The additional expenses are not deducted from his competitor's salary.

We have considered the actual cash pay the doctors receive, we believe it to be far less than that received by his competitors. We now will emphasize the difference in the hours of labor and the more hazardous character of his work. His competitor works from eight to twelve hours a day, rarely ever works late into the night—the work always growing easier and the hours of labor less as the pay increases; whereas, on the contrary, the doctor's work must increase in the direct ratio as his salary advances. His competitors can be absent from their work for days, weeks, and even months, either for sickness or for pleasure, and have their pay go on, while the doctor's salary must pay the penalty for every minute of absence from duty.

Can we reckon in dollars the doctor's pay? Are we ever compensated in cash for those long weary hours at the bed-side critically watching the restless, nervous, sleepless patient? Are we ever compensated in dollars for those long weary vigils with the expectant mother, bearing with her the pain and anguish which nature and civilization have inflicted? Does the laity believe that money could repay the strains of those terrible midnight calls, those "Doctor, please come quick, my wife is dying," when the road is long, cold, muddy and weary, and the night is hideous with rain and darkness? Does the laity believe that money could repay those tiresome, wearisome, vexatious questions of our own friends and relatives? I believe in all candor that if we were not compensated by the love of our scientific profession, the love of duty performed for suffering humanity, the gratitude of our patients and the godliness of our calling, few doctors would long endure the hardships of the profession for the paltry cash pay.

The doctor who does not fully appreciate the high character of his work and who charges such small fees that he cannot afford to buy the best drugs, well equip himself with instruments, scientific appliances, does himself injustice, and his community even greater injustice.

A New Method of Treating Swamp Fever.

By E. DUNBAR NEWELL, St. Joseph, La.

By swamp fever, I mean hematuria, hemoglobinuria or hemorrhage from bowels, all caused by malaria.

Edwin B., white male, age 12 years. His father and mother were born in Tensas Parish and have lived there all their lives. Both parents are in fairly good heatlh, and rarely have malarial attacks. Their home is three and one-half miles back from the Mississippi River on well drained, open, cultivated cotton land. There is no stagnant water near their home, and there are no shade trees. All their drinking water comes from a cypress tank buried in the ground that is filled from the gutters around the house. This was supposed to be entirely rain-water, but by "osmosis" the sub-soil water that surrounded the tank filtered into the tank, so they drank part rain water and part shallow sub-soil water which, of course, contained surface drainage.

Within one hundred feet of their home was a cross-road eating house, and the offal from fish, at times during very hot weather, was very disagreeable, but with these exceptions the general sanitary conditions of the house and surroundings were unusually good.

The boy had been having attacks of chills and fevers all summer. On Monday, November 7, at 3:45 a. m. I was called to see him. He had a malarial chill the previous Saturday at 10 a. m., doesn't think he had but very little fever that day, but had decided fever Sunday. This morning he took 4 grs. quinin sulphate at 4-6-8 and had a chill at 9 o'clock a. m. Has been cold and nauseated all day. At 3 p. m. had free normal action from kidneys and slight bloody stool. When I saw him at 3:45 p. m. he was intensely pale, lips, ears and finger tips cold and purple, very nervous and restless, extremely nauseated, but not vomiting, pulse fast and weak. Abdomen was intensely congested and felt like dough. You could not distinguish liver and spleen dullness from the dullness of the abdomen. I had very little hopes for the patient's recovery.

At 3:45 I gave 1-200 gr. atropin sulphate and 1-60 gr. strychnin hypodermically. In a few minutes he had another bloody stool. Hot water bags were put all around him.

4:15—1-150 gr. digitalin hypodermically.

4:15—Another very dark bloody stool. I put on large mustard plaster to abdomen. At 5 o'clock gave 10 drops adrenalin chlorid solution.

The adrenalin solution did not increase the nausea and did not make him vomit, nor did it any time, although these patients' stomachs are extremely sensitive to anything. The first two actions from bowels were bright red, the third was dark and very offensive. 5:40 we gave 5 grs. calomel and 1-2 g. pulv. capsicum on shaved ice. At 6:10 patient was sleeping quietly. At 6:25 pulse 120, resp. 22; 7:10 o'clock, 10 drops adrenalin chlorid solution; 8 p. m. all doughy feeling had disappeared and there was the usual tympanitic note over abdomen. The adrenalin was continued every four hours all night and tr. nux vomica and liq. potassi arsenitis every three hours.

At 5:30 a. m. of the 8th he passed one pint clear normal urine. 6:30 very dark, bloody stool, composed mostly of clotted blood that had been retained in the bowels from the congestion. At 8:30 we began teaspoonful doses of magnesium sulphate in Celestin vichy every hour. 9:25 dark bloody action. 10 gave first nourishment of equal parts milk and vichy. He was encouraged to drink Celestin vichy freely all during this attack and the subsequent ones. 11, small stool that was free of blood; 11:45, very full normal stool; 4 p. m., temperature normal.

November 9. Temp. 98°, pulse 92. He did not have any more blood in his stools. The adrenalin, 10 drops, was kept up every four hours for a week, and after that time every six hours. The arsenic and nux vomica were continued every six hours. On Sunday, November 13, had a slight chilly sensation. Tuesday, the 15th, he had a very decided chill and high fever. We then gave euquinin as the arsenic and nux vomica had failed to prevent the paroxysms. He took adrenalin all during this time. Although he had a hard chill and high fever there was no congestion and no blood from either kidneys or bowels. He got up on November 20 and was up for one week and was improving nicely. On Monday, November 28, he was kept in bed in anticipation of the fourteenth day paroxysmm the next day, Tuesday, was the fourteenth day from last chill—and was given five grains euquinin at 6 and 8 a. m. At 6 a. m. he had free perfectly normal action from kidney and a large normal stool. At 7 o'clock he was feeling perfectly well and complained of having to stay in bed. His temperature was normal and had been so for some days. He ate his breakfast with relish. At 9 o'clock he had an action from kidneys that was the bright red color of diluted blood—not bile color. At 9:45 he had another passage from kidneys that was darker than first time, but still had the bright tinge of fresh blood. When heated it turned dark brown and coagulated. Examined under the microscope, it did not show any blood corpuscles. At 11, temperature 100°, pulse 90, liver not enlarged, spleen not enlarged, abdomen normal, tongue perfectly clean and moist, face bright and cheerful, pulse full and strong. Extremities warm and natural, no nausea, no discomfort of any kind and not the slightest indication of chill. 11:45, temperature 101 2-5°; 12:30, became very nervous and complained of pain in abdomen. Put on large mustard plaster over abdomen and he was soon sleeping quietly.

He had several other bloody passages from the kidneys during the day, but by 6 o'clock that evening the urine was normal in color. In two or three days he was up again, but we did not give him any more euquinin. The adrenalin and arsenic and nux vomica were continued every six hours.

Sunday night, December 4, he began to take adrenalin and the arsenic and nux vomica every four hours. Monday he was kept in bed and given very light breakfast. At 12 o'clock he complained of nausea and became pale, but did not get cold or have rise of temperature. On Tuesday, the regular 21st day, he had a slight chill and at 1:30 temperature was 100 2-5; it later went higher. The adrenalin and arsenic and nux vomica were continued every four hours. On Wednesday he had another chill at 11:40 with rise of temperature to 102 2-5°. The urine continued normal after both of these chills, and did not show any albumen. The passages from the bowels were normal also.

On the 11th we sent him to Monroe, La., not as a health resort, however, but to give him a change of surroundings and to revive and rejuvenate his spirits.

He had a chill on his way over and one after he had gotten to Monroe, but he had no more after that, and is now in good health. While in Monroe he was under the care of Dr. Faulk.

The points of especial interest in this case are these:

That on November 7, when he had the first congestion, it had been preceded by 12 grains of quinin sulphate; that on November 28, when patient was feeling perfectly well, it was not his chill day; that two hours after he had taken 10 grains of euquinin he had congestion of the kidneys without the slightest chilly sensation. Now, in regard to the use of adrenalin chlorid solution in this case, the patient had four malarial chills after the first severe chill, *namely: On November 13 and 15 and on December 6 and 7, but he did not have the slightest hemorrhage from* either the kidneys or bowels.

In these chronic malarial cases, when you have chills, closely following the first chill with hemorrhage, your case usually terminates fatally.

I believe that the adrenalin chlorid given continually, as was done in this case, although it did not prevent the chill, did prevent the severe congestion that is usual in these cases.

The Treatment of Complete Prolapse of the Rectum by Rectopexy.

By S. P. DELAUP, M. D., New Orleans, La.

It is not my purpose in this paper to enter into a discussion of the etiology, pathology, symptomatology and classification of prolapse of the rectum, but simply to consider the surgical treatment of that affection. By prolapse of the rectum or procidentia recti is meant a protrusion through the anus of the rectal wall, caused by a lack of support. If the mucous membrane alone protrudes the condition is known as incomplete or partial, complete when all the coats are involved. This affection is common to both sexes and at all ages and conditions, but is most frequently met with in children and old people and more often in women than in men.

The principles upon which the cure of prolapse depends are: First, the removal of any exciting cause; and, secondly, the restoration of the supports which have been destroyed or altered. The exciting causes in children are most commonly diarrhea, constipation, phimosis, whooping cough, lack of muscular tonicity; in fact, anything which causes undue straining. In adults, besides the causes stated above there may be vesical calculus, enlarged prostate, tumors of the bladder or vaginal wall.

Complete prolapse occurs less frequently than the other variety. It is met with most frequently in persons past the middle life.

The operations devised for the relief of prolapse of the rectum are numerous, but only those will be described which have been tried with success. Any operation to be successful, says Gant, must accomplish the following objects:

1. Produce sufficient inflammation to cause an adhesion between the rectal coats so that one will not slip over the other.
2. Remove redundant tissue in order that the caliber of the bowel may be narrowed.
3. Reduce the size of the canal aperture.

The method of treatment to be selected will depend upon the point at which the prolapse begins and the extent to which it descends. In those cases where only a small portion of the lower end of the bowel comes down, the methods which narrow the arms and thus obviate the protrusion will be effective. Appreciating these facts, Van Buren devised a method for restoring the adhesions between the coats of the rectum by setting up an inflammation in the rectal wall and thus causing agglutination.

Van Buren's operation is performed as follows: After the bowels have been thoroughly cleansed and the patient has been anesthetized, the prolapse is dragged down as far as it will come, cleansed and dried, the Paquelin cautery is applied in lines about half an inch apart all around the circumference of the rectum extending from the margin of the anus to the highest point of the prolapse. This method of treatment is especially adapted to prolapsus ani, a condition in which only the mucous membrane is affected; but, in very large prolapse with thickened and hypertrophied walls, the method is not likely to result in permanent cure. Where the prolapse is of small extent the removal of folds of mucous membrane at three or four points around its circumference by clamp and cautery has frequently proved entirely successful.

The procedure of cauterization with excision of the mucous membrane is performed in a manner similar to the clamp and cautery method for treatment of hemorrhoids. If the cauterization is followed by hemorrhage the edges of the burnt wound should be stitched together by a continuous chromicized catgut suture. Not more than four folds of the mucous membrane should be treated in this manner, to obviate danger of cicatricial contraction and stricture.

One may also, in suitable cases, dissect off elliptical strips of mucous membrane, bringing the edges together with chromicized sutures, thus narrowing the lower end of the rectal canal. Other operations such as cauterization of the whole anal skin in order to form a circular scar, or Thiersch's to reduce the caliber of the anal ring by means of a silver wire passed subcutaneously, are of too limited a character to deserve more than a passing mention.

The second method of treatment intended to cure prolapse of the rectum is the resection of the protruding bowel by the aid of the knife, cautery, elastic ligature, or ecraseur. This method has been practiced by both ancient and modern surgeons with varied success.

The conditions which seem to justify resection or amputation are: The existence of extensive ulcerations, of neoplasms involving the entire thickness of the rectal wall, organic strictures, gangrene or sloughing of the protruded gut and adhesions such as prevent reduction.

The removal of the bowel is accomplished by making an incision around and through the bowel immediately above the sphincter, and with the finger or blunt scissors carefully separate it from the surrounding structures as high up as necessary. Grasp it with the fingers or forceps, pull down until taut, and amputate the now protruding portion. Unite the stump to the lower segment with interrupted chromicized catgut or silk sutures.

Resection of the prolapsed rectum as thus carried out is not without danger on account of the length of time of the operation, loss of blood, and the further fact that it is difficult to disinfect the parts. Death from hemorrhage, or rupture of the suture line with resulting peritonitis, has been but too frequently reported. If the patient recovers from the operation, he still runs the risk of either stricture or recurrence of the prolapse.

In spite of these drawbacks, resection is a most valuable method of treatment.

In minor degrees of prolapse the condition may sometimes be relieved by some modification of the Whitehead operation. The mucous membrane is dissected from the prolapse, excised, and the cut borders sutured to the margin of the anus, thus folding in that portion of the bowel which was prolapsed. These operations, limited to the mucous membrane, have often proved ineffectual, and many procedures involving the deeper tissues have been devised.

Another method of treatment of prolapse is known as rectopexy or sigmoidopexy. The principle is to replace the prolapsed bowel and to fix it in its original position by some method of suture. If the rectum itself is sutured, the operation is spoken of as rectopexy; and if the sigmoid flexure is sutured the term sigmoidopexy is employed. Sigmoidopexy, or ventral fixation of the sigmoid flexure, as a cure of prolapse of the rectum, was proposed by Jeounel in 1889. It is based on the theory that the rectal prolapse is due to stretching of the mesorectum and the mesosigmoid. He performs the operation as follows: Through a short incision in the left hypogastrium, the sigmoid flexure and rectum are drawn upward until the prolapse is completely replaced. The corresponding part of the bowel is then stitched in the wound by means of a serosa-muscular suture. To make the fixation more firm, the mesosigmoid may also be stitched in the wound to the parietal peritoneum. If the uterus is also prolapsed, it may be fixed in the lower angle of the same wound. The abdominal wound is then closed. Von Bergmann says that an examination of the records of thirty-three cases of sigmoidopexy shows that a cure was effected twenty-six times, while in seven cases there was a partial or a total recurrence. He further states that the period of observation was not long enough in most cases to show the permanency of the cure.

Most surgeons advise this method of treatment, and assert that it is both simple and without danger. To judge from a recent hospital observation I believe that this operation is not without danger, since two cases on whom it was performed died, one from paralysis of the bowels, and the other from peritonitis, caused by a slough of the abdominal wall. In both cases the operators were well-known surgeons of ability, especially skillful in abdominal surgery.

Rectopexy, first proposed by Verneuil in 1889, then modified by Fowler, consists in suspending the rectum by sutures carried around the coccyx and sacrum. For the technique of the operation I quote Tuttle, the chief advocate of the method:

"The patient is prepared by a thorough cleansing of the intestinal canal, shaving the perineum and sacral regions. After being anesthetized the prolapse is dragged down to its full extent and held forward by an assistant. A curved incision about two inches in length is made midway between the coccyx and anus. This is carried through all the tissues into the retrorectal space. With the finger or a dull instrument introduced through this incision, the rectum is separated from the coccyx and sacrum posteriorly as high up as the attachment of the mesorectum and on the sides as far as the attachment of the lateral ligaments. The anterior surface of the bone is then gently curetted to remove all the fatty tissue and to freshen it. At this point the assistant reduces the prolapse and with the fingers inside the gut brings it out through the incision; the operator catches the protrusion and drags the gut down as far as it will come, usually a little less than the amount prolapsed, through the anus. The external surface or muscular wall of the gut thus exposed is then curetted as was the sacrum. Silkworm gut or silver wire suture are then passed transversely through the muscular layer, embracing as much of the circumference of the gut as possible; they are placed half an inch apart, and the ends left 6 or 8 inches long. After the sutures have been placed, the ends of the upper ones are each in turn threaded on a long curved Peasley needle and carried up through the wound to the highest point of the separation between the rectum and sacrum, where they are made to penetrate the tissues, and are brought out through the skin on opposite side of the bone. The other sutures are treated in like manner, each being brought out half an inch lower than the preceding one. The ends are then drawn taut, and the prolapse is thus dragged up into the hollow of the sacrum, where it belongs. A pad of gauze is laid over the sacrum, and the sutures tied over this to avoid their cutting into the skin. Before tying the sutures the space between the rectum and sacrum should be freed from all clots and the oozing checked. The gut is thus anchored in close apposition with the sacrum to which it unites in due time. The external wound is closed by buried catgut and subcutaneous sutures. If the sphincters are much relaxed or overstretched, a ligature of kangaroo tendon is passed around the anus at the upper margin of the external sphincter. This narrows the anal outlet and causes contracture of muscle, thus contributing to the cure. The bowels are confined for eight days, when they are moved by enemata. The patient is required to remain in bed and use the bed pan for three weeks, after which time he may be allowed to go to the toilet. The anchoring sutures are left in from 10 to 14 days."

Thus far no fatal case of rectopexy has been reported. Suppuration has sometimes followed this operation, defeating its purpose. The difficulties of this method, aside from the risk of infection, rest in the fact that the sutures are liable to cut their way through the flabby tissue.

As to the choice of operation I believe that the best treatment for prolapsus ani, or prolapse of the first degree, is cauterization of the superfluous membrane. If the prolapse is irreducible or gangrenous, or complicated with ulcers, the method by resection is indicated. A very large prolapse may be treated by resection, or sigmoidopexy. The latter operation is simpler, entails less risk, and produces about as good results as the former. In uncomplicated prolapse even of large extent, 6 to 8 inches say, rectopexy by Fowler's method is the best, as it assures the best results with the least danger.

In a case successfully operated by myself, and here reported, I combined the three methods, rectopexy, linear cauterization, and excision of folds of mucous membrane.

A negress, 34 years of age, married and sterile, is admitted into the hospital on February 13, 1905. On examination she gives evidence of syphilis, her face is swollen, her eyelids œdematous; she generally has a sleepy appearance. Urine examination reveals a condition of nephritis. Her heart and lungs are normal. The vaginal outlet is partially closed by a hard cicatricial band occupying the lower half of the vulva, this being evidently the result of a former ulceration. The rectal trouble began about three months before her admission, appearing suddenly after a slight exertion, and has gradually increased in size to the present length of about 7 inches. At first the prolapse could be reduced and retained, but latterly it is reduced with difficulty and cannot be retained. Owing to her inability to sit down or to walk with comfort she was put to bed and put on a palliative treatment, consisting of rest in bed, stimulating diet, tonics, mild laxatives, baths, and protective dressings. After eight days of preliminary treatment, she was made ready for the operation. She was placed in Sims' position and under special cocainization a semilunar incision looking upward was made midway between the tip of the coccyx and the anus. The incision was deepened to expose the inner surface of the coccyx, then with the fingers and blunt elevator the separation of the rectum from the sacral wall was extended up as far as the fingers could reach. Then my assistant reduced the prolapse, and with two fingers in the rectum forced its posterior wall through the external wound and three sutures of heavy chromicized catgut were passed transversely through the posterior rectal wall, including all its tissue, to the mucous membrane. The first suture was passed as high as possible, the others about one inch apart. To facilitate adhesion the denuded sacral wall and the portion of the rectum grasped within the sutures were curetted lightly. Then each suture in turn was threaded to a Peasley needle and brought out on the posterior surface of the sacrum and coccyx. Traction was made on the sutures and the bowel drawn up against the sacrum. To demonstrate the thorough reduction by the sutures, the patient was asked to cough, which caused the gut to again protrude. Before reducing it again, I made three linear cauterizations with the

Paquelin cautery. Also three redundant folds of mucous membrane above the anus were excised and sutured with chromicized catgut. Irregular tags of skin around the anus were likewise removed with the cautery, which was further applied around the anal margin. The sutures were now tied on a pad of gauze, the curved incision between the coccyx and anus closed, except at the central portion, where an iodoform gauze drain had been inserted. The analgesia was complete and the patient left the table in just as good a condition as when she was brought in. The after treatment consisted in stimulating liquid diet, daily irrigation with normal salt solution and 1-8 gr. morphine by mouth every six hours. In spite of opiate the bowels moved on the third day. From at first retention of urine she suffered from incontinence, which condition gradually improved, though not completely. At the time of her discharge she still was slightly inconvenienced by dribbling of urine on the slightest exertion. The patient left the hospital two months after her admission in good condition, with perfect control of her bowels, with no sign of recurrence of her prolapse, and with an anus reduced to about the normal size.

Before closing this report I wish to add two other cases of complete prolapse of the rectum cured by rectopexy. These cases were operated on two years ago by Dr. Chassaignac, whom it was my pleasure to assist, and as yet there has been no recurrence.

The Bites of Insects.

By ISADORE DYER, M. D., New Orleans.

In the ordinary divisions of diseases of the skin one group includes the animal parasitic diseases. In this division are embraced a variety of insects which are truly parasitic upon the human skin, either living in the skin and feeding on contiguous tissue, or else living in the appendages of the skin, the clothing, and feeding on the human blood. This group embraces the *Sarcoptes scabei,* the *Demodex folliculorum,* the three varieties of *Pediculus,* the sand flea (*Pulex penetrans*), and the *Pulex irritans,* or common flea; the guinea worm, *Cysticercus, Echinococcus; Leptus autumnalis,* or red-bug, the *Ixodes,* or tick; the *Cimex lectularius,* or bed-bug; the

Culicidæ, or mosquitoes; *Simulia,* or midges; bees (*Apes melliferæ*), and wasps (*Vespidæ*).

Only here and there in the history of dermatology is any reference made to the characteristics of these, and then only in their relation to some other disease. The researches of Nuttall, Manson, Laveran, and the numerous other experimenters with mosquitoes, have shown a direct relation to systemic infection. The domestic fly and the bed-bug have now for some years borne the burden of accusation in the responsibility for local and general infective conditions. Speculation has arisen at various times regarding the role other insects play in a variety of diseases. These have been overshadowed by the peculiar prominence which has attached to mosquito investigation.

The present paper is briefly directed at calling attention to the local evidences which present in each of the conditions for which insects are responsible; it is intended to attract attention to the early recognition of the lesion, or lesions, which each presents so that they may be recognized when seen.

It is curious but true that no two of the parasites and accidental insects which attack the skin show an identical lesion under these circumstances. Any area of attack may on its own merits be differentiated at a close examination.

We may divide the parasitic enemies of the skin into two general divisions; those which are common to the human skin, and those which are extraneous. In the first group belong scabies, the pediculus, demodex and filiaria. In the second group belong all the rest of those enumerated.

Scabies presents a vesicle at the point of its burrow; the pediculi are marked by papules or pustules from infection. The guinea worm forms a tumor which ulcerates.

Now all of the other parasites named above present as the evidence of their presence some sort of a wheal. In some instances the circumscribed edema is caused by the presence of the parasite in the skin itself, viz., the tick, red-bug, cysticercus, etc. Others occasion the lesion either by their selection of the human skin for feeding purposes, *e. g.,* the flea, bed-bug, the mosquito, or the lesion is the result of a venom infection occasioned by an inimical incision by the proboscis or other instrument of the insect disturbed in its natural pursuits. In this last case we would include the bee, wasp, spider, etc.

A careful study of the clinical evidences of each of the above groups and their individual components would show that even then differences are to be noted.

The *Demodex folliculorum* is actively associated with acne and rosacea, and in its occupancy of the orifices and ducts of the fat glands occasions a papule, irregular in size.

Ixodes, or wood-ticks (Nat. order *Acarina*) bury their proboscis in the skin and determine a small wheal at the point of entrance; the body of the tick grows in size until the tick is thoroughly engorged, when it falls off.

The *Leptus autumnalis* is the familiar "red-bug" of this section; it is a six-legged larva of the species *trombididæ.* It finds its sites of selection on the legs, but may travel to the arm-pits, cruro-scrotal region or over any part of the body. The lesion is either a small red papule, or a wheal, hard, rounded, and with the bug in the center. The insect drives its head into the skin and the intense itching resulting occasions the victim to scratch a central hole in the lesion in the endeavor to remove the head of the bug.

Pulex penetrans, "sand-flea," "chigoe," "jigger," is found in dry sandy soil in tropical and subtropical countries. The fecundated female burrows into the skin, usually of the feet, between the toes, but the insect may travel to other protected parts of the body. The lesions are vesicles, usually numerous, as the irritation is intense and the resulting scratching may occasion extensive dermatitis or even ulcerative processes.

Pulex irritans, or the common flea, friend of the dog, his usual host, or the hog, or the cat. The flea is a bloodsucking breed and bites either in search of food or for protection. The lesion is always small, the size of a half pea—is a wheal and almost invariably occurs in pairs. No other insect bites twice as does the flea, with the two lesions arranged like dumb-bells.

Cimex lectularius is the euphonious name of the common bed-bug, which is only too familiar. It is an accidental parasite on the human skin, sucking blood, or biting for defense. The puncture of the proboscis of the bed-bug carries with it some toxic element which is productive of intense inflammation, locally, and at times resulting in severe constitutional irritation, with fever or severer symptoms. The central puncture, often hemorrhagic, is surrounded by a halo of edema, fantastic in outline, classed as wheal, but varying from a simple reddened area to a gyrate lesion as large as the hand or even larger, with swelling out of all proportion to the evident exciting cause. The itching is intense and excoriations frequently mark the site of the edematous lesions.

Some *Flies* attack the human skin, usually nipping a small papule to the surface. As a rule the edema is not marked.

Ants biting the skin create small hemorrhagic papules with a burning sense of irritation rather than the itching associated with a deeper intoxication.

The *Spider* of ordinary varieties biting the skin usually does so with venomous instinct. The central point of the wound is always characterized by a small vesicle, surrounded further by a circle of edema. This circle of edema is as typical of the spider bite as is the central vesicle. At times, on sensitive areas, as the scrotum, a marked edema may additionally develop around the original lesion. This will depend upon the venomicity of the insect.

With such spiders as the tarantula, etc., attacking the exposed parts, and especially the hands, a rapid destructive lesion forms. It is initiated with a vesicle, which increases several times its original size, with a deep seated edema associated. As soon as the acute evidences of the toxic infection is over, there are lines of definition of destruction and the area of original infection, the blister area, sloughs.

Bees bite only when disturbed and with a lancinating puncture, usually appearing as if double cut. The swelling is prompt and protuberant, rounded like a half egg in the skin, the lesion is usually reddened, but may become edematous wholly or in part.

Wasps and *Hornets* bite alike. The lesions are almost always on the hands and face and are multiple because these insects are ordinarily encountered near their nests, and there they seldom travel alone. It is unusual to see a single hornet or wasp attack the skin, and if such be so, it is only after continued provocation. The lesions of the wasp's and hornet's bites are small, highly inflamed and with a red center and edematous areola. This last may merge into adjacent lesions, so as to give the impression of a suffused mass of edema with islands of red scattered all over the field.

Mosquitoes bite in two ways: If undisturbed the proboscis finds the tip of a papilla of the corium, sucks constantly until surfeited and then flies away; less carelessly the proboscis is driven into the skin without intelligence, it breaks between the papillary prominences, sucks away, draining blood from this area and as a result occasions an edema here.

The first method seldom annoys, while the second occasions intense itching and more readily disturbs the victim of the bite. In the first type of bite it is no unusual thing for a person to fall asleep and after half an hour or so to wake with a spotted face or hand. It is this small hemorrhagic, erectile papule, which dots the face like an eruption of measles, or rings the wrist or ankle with a double or triple line of red dots. The others are deep seated, small, wheals, which itch, even recurrently, after the bite has been recorded.

There may be other insects which bite the skin, but as a rule the interest attaching to these is much more personal and individual than general. This paper is aimed at creating a more general observation of these things in order that with information arising from such direction the writer may deal exhaustively with the subject at a later date.

For the present it should serve some purpose to point out the differences in the evidences of the little enemies, that they may be duly recognized when seen.

Remarks on Abscess of the Liver.

By L. SEXTON, New Orleans.

Abscess of the liver requires more skill in diagnosis and treatment than any other diseases with which we have to deal in tropical climates. The beginning of the abscess is so obscure, its development so insidious, that even the presence of pus at times is hard to determine. Abscess of the liver may be confounded with intermittent malarial fever, right sided pleurisy, cancer, gall stones, and suppurating hydatid cyst.

Chronic abscess of the liver may exist for a long period of time, hardly producing any symptoms further than malaise and low fever. Dr. Rose operated upon a case of abscess of the liver that had existed for twelve years as proven by previous hypodermic puncture.

Multiple abscesses are usually pyemic, or secondary, resulting from emboli which have been carried from either suppurating piles, typhoid ulceration, or operations upon the head, or appendicial inflammation through the portal vein or from general systemic infection through the hepatic artery. Cholangitis resulting from pyogenic organism from the intestines, or gall bladder, may also result in multiple abscess of the liver. In all these pyæmic metastatic abscesses, treatment either medical or surgical is of little avail. It is the single tropical abscess with which this paper has to deal and in which operative interference is demanded early, for there is really no medical treatment of any permanent good in such conditions. Traumatism, hydatid cysts, or gall stones may be the beginning of single abscess. The ameba coli of dysentery has been found so often in liver pus that it has been said to be the cause in the majority of cases, though it may be a coincidence and not the real cause.

Seventy-five per cent. of the single abscesses either co-exist with or follow dysentery; 75 per cent. are located in the right lobe of the liver and are of embolic origin. Dr. Cantlie contends that tropical abscess of the liver is dependent upon lymphangitis resulting in suppuration, and that sudden chilling of the surface after excessive heat causes the inflammation of the lymphatics of the liver, where there has been no preliminary dysentery, and if there had been, he claims it to be almost impossible for emboli or fluids from dysentery to get into the liver lymphatics.

The colon bacilli and amebæ are occasionally seen; the bacteria of suppuration may also be found in the liver abscess; the pus is sometimes sterile, supposed to be so from its chronicity having disposed of the septic organism originally in the case. Symptoms are so light in some cases that the liver abscess is not suspected until a rupture resulting in general peritonitis takes place; the more acute cases are accompanied by fever of 102 degrees or more; enlargement, tenderness and pain over the liver, with profuse sweating are first symptoms; there is a dread of deep breathing, occasionally slight jaundice; nausea, foul tongue, shoulder, head and back ache, and the usual febrile conditions associated with pus formations; weight and fullness in the right hypochondrium; percussion shows increased liver dullness.

The intrahepatic abscess is often associated with an attack of dysentery; the relation between the two attacks is accounted for by the absorption of emboli from the dysenteric ulcer of the intestines which are arrested in the branches of the portal vein in the liver; some of these single tropical abscesses involve half of the liver structure; the other half of the liver does the physiological work for the whole, which is secretion of bile, formation and storage of glycogen, the production at least at a certain period of development of blood corpuscles, also the destruction of blood corpuscles, the formation of a large quantity of urea, the retention and destruction of certain poisonous substances absorbed from the intestinal tract. Suprahepatic abscess may open into any of the hollow viscera or into the pleural or peritoneal cavity.

Liver abscesses occasionally open through one of the bronchial tubes. The red liver pus being expectorated by this route has been mistaken for rusty sputum of pneumonia. Whenever there is pus, let it out, applies as well to liver as to other abscesses. If adhesions have taken place and the abscess is pointing to the abdominal parieties there is no risk in a free puncture provided adhesions are perfect; if adhesions have not taken place it is prudent to either stitch the periotoneum to the abdominal wall or pack the incision and to wait for adhesions, opening the abscess under cocain at a second sitting.

If the pus should burrow upward through the diaphragm and bulge at one of the intercostal spaces a free incision should be made in the cavity; if there is plenty of space between the ribs it is not necessary to resect; but free drainage must be attained even at the expense of a section of the rib. Such cases are practically empyema and should be treated accordingly.

There is no variety of abscess where delay in operating is fraught with more serious consequences than in abscess of the liver; hence whenever the symptoms point strongly to this condition an aseptic explorating aspiration should be made; the skin should be incised under cocaine, then with an exploring needle attached to aspirator with either vacuum bottle or with piston vacuum as soon as the needle is inserted, when a careful search for the abscess cavity is made; the advantage of the vacuum is that by a slow insertion you will detect the pus in the barrel of the syringe as soon as the abscess is entered and not run the risk of driving the needle past the pus cavity, and thus defeat your diagnosis. When adhesions have occurred to the abdominal wall a trocar is inserted into abscess which forms a guide to a free opening either by knife or by inserting and opening dilating forceps. Any broken down liver tissue should be removed, all the pus possible drained out by position and pressure and any hemorrhage stopped by gauze packing. One two or three-quarter inch rubber drainage tube with large safety pin passed through the end should be kept in the opening to serve as a drain. It is usually not best to wash out these cavities, but if the abscess is very large and pus offensive, if we can make a counter opening or insert two large drainage tubes instead of one, a douching with boracic acid solution or creoline, one to six hundred may be used; but with free drainage, douching is to be discouraged. This is equally true with meddlesome interference by inserting the finger into abscessed cavity. When no adhesions are found to exist, pack the incision, wait for them to form or stitch the liver tissue to the abdominal walls, but owing to the friable state of the liver tissue, sutures do not hold as they would in firmer structure. Dr. McLeod, of Shanghai, uses a metal drainage tube and claims that all stitching of the liver to the covering soon gives way.

In deep seated abscesses the Manson trocar and canula method of opening proves very satisfactory; this method can be resorted to in the earliest stages of the disease; if the abscess is four or five inches deep the cutting operation is rather more radical than the insertion of a canula to drain the same; if the abscess is not seen or is left to bulge towards the abdominal wall or costal region an incision is more practical by the Manson method. A large trocar six inches long and three-eighths of an inch in diameter is inserted down to the abscessed cavity, which has been previously located with an aspirating needle. The next procedure is the introduction of a larger indiarubber tube than the diameter of the canula; the rubber tubing is one-fourth to half an inch in diameter and ten inches long, with apertures near the bottom of the abscess to drain out the pus. When the canula is withdrawn we have a wide tube leading to the bottom of the abscess cavity, a loop of thread is passed through the end of the tube which is then covered by a large absorbent dressing. Dr. Mitchell treated four cases successfully by this method, Dr. Turnbull three cases, Dr. Cantlie seventeen cases, with four deaths. Irrigation was not used by them. Rubber tubes should be left in as long as the discharge continues. Manson plan gives the best results in small, deep seated abscess; its insufficient drainage is its principal criticism. Where the case has not been diagnosed until bulging has occurred it is usually safe to incise, but we are not justified in such a tardy diagnosis. With thorough asepsis and gentle manipulation the aspirating needle is the only positive way of making an early diagnosis; if pus is found five inches deep by puncture through the intercostal space, the trocar and canula method is the safest way of operating.

Following the above suggestions I have had two successes and one failure in treating abscess of the liver within the past two years.

Case One—A merchant, age 45, previously enjoyed good health with the exception of tubercular glands of the neck, which had been removed, and a recent attack of la grippe; was sick for twenty days with what his physician called bilious fever; temperature averaged about 102 degrees, pulse 100, breath foul, and tongue coated; tenderness and enlargement over the liver; deep breath caused pain. With a large aseptic aspirating needle inserted, after an incision had been made through the skin, the piston of the syringe was drawn up so as to form a vacuum in the aspirator; this caused the pus to flow into the barrel as soon as it was reached. We detached the syringe and left the needle as a guide and made free incision into abscess, inserting two drainage tubes; did not irrigate. Patient was instructed to remain on right side as much as possible. An uneventful recovery was the result. This abscess was most likely of grippal or tubercular origin.

Second Case—A bookkeeper by profession with very much the same history; no dysentery, but with a history of chronic malaria;

attributed his liver abscess to leaning forward on the desk upon which he was writing. Diagnosis verified by aspirator, free incision through abdominal wall and drainage effected a cure.

The third and fatal case followed typhoid fever and was not diagnosed until bulging of the abscess had taken place. We made a free incision and drained off an enormous amount of pus, which must have occupied two-thirds of space of his liver. He lived ten days, pus discharging freely all the time, but gradually died of exhaustion after having been sick about two months.

CONCLUSION.

Abscess of the liver may follow malaria and typhoid fever on account of the congested condition of the liver occasioned by these diseases. We may have abscess of the liver with absence of fever, dysentery and jaundice.

Aseptic aspiration is the only positive way of clearing up a diagnosis of pus in the liver. The finding of malarial plasmodium in the blood or the amœbæ coli in dysenteric stools aids in the diagnosis.

With perfect adhesions, no leaky drains, the prognosis in single tropical abscess of the liver should be favorable.

Free drainage without irrigation is the safest rule in treating abscess of the liver. Perhaps dysentery as a cause of liver abscess has been exaggerated, as it may be a coincidence in some cases instead of the real cause.

The Insanity of Epilepsy.

By D. E. M. HUMMEL, Jackson, La.

It is the purpose of the present brief article to direct attention to some of the most common and characteristic features of mental derangement associated with this as yet mysterious disease. That the subject is important is constantly emphasized in medico-legal circles; for some of the most revolting depredations known to criminal annals have been perpetrated by this class of defectives. Society is the more defenseless in such instances because the violence is usually done without sane motive, or warning to the victim.

My observations have for the most part been limited to epileptics with marked insanity, and these inferences are drawn from extreme cases. But I do not wish to be understood as assuming that epilepsy utterly mars the mental life of most individuals so afflicted. Many of them live usefully in certain walks of life and make good citizens. As a matter of course, cases are not often committed to an asylum because of their convulsive seizures only. In many instances, though, their plight is even worse, notwithstanding they retain their nominal liberty. Ostracised, shunned, tabooed on every hand, they are shut out from congenial association with their fellow men, barred from most useful vocations or opportunity of mental advancement, they become biased, stunted and misanthropic in mind; which circumstances might be reckoned as to some extent accountable for many of their vicious, resentful proclivities. Now and then we read in the columns of the daily press of some terrible crime committed without provocation or incentive, not only so, but counter to the strongest natural instincts, as the assault and murder of children by parents. Subsequent developments frequently prove the offender to be subject to epileptic convulsions.

Obviously the chief value or interest of discussion of the subject will be in the recounting of characteristics by which might be distinguished the acts of an insane epileptic, when it becomes important to establish his legal status as a member of society; or whether he really be an epileptic.

THE EPILEPTIC DISPOSITION—As inferred above, very few of these unfortunates are amiable or "good natured," at their very best. Most of them are morose, pessimistic Ishmaelites. These tendencies color their insane moods as well. In asylums they are frequently offenders against discipline, and most disagreeable to their associates. At certain times they exhibit an obstinate, apparently resentful manner toward everything and everybody. For instance, it is frequently very difficult to treat their injuries received from falls and convulsions, as they are most prone to disarrange the dressing or appliance as fast as it is readjusted—especially if told not to do so. They bicker and nag at other patients about them. Under these circumstances some of them can be ingeniously mean—as the meanness of irresponsible persons is rated. All the time their religious pretensions may be extreme. I have in mind a patient who spends much of her time reading the Bible and singing psalms. She nevertheless is nearly always in a personal encounter with one of her fellow patients. Because of their peculiar affliction anything simulating ordinary consistency is practically never the trait of an insane epileptic. Many of them are given to pilfering all sorts of articles. Unable to get hold of anything of value, they will gather worthless trash of every description to conceal about their rooms and bedding. There is usually a big row when they are robbed of such stuff. Utterly without the sense of ethical considerations, they, by a kind of atavistic instinct, indulge the habit of appropriating everything in sight. Many of these obliquities are insane traits, of course, but I have mentioned them just here to indicate the tendencies grosser offenses are apt to take.

THE MAJOR PSYCHOSES—In this connection reference is had to the transient states of reduction which students of mental diseases regard as having intimate relation to the convulsions proper. Such attacks are usually of short duration and self-limited. They may occur immediately preceding or following a fit, sometimes persisting throughout the whole inter-convulsive period when a rapidly recurring series of seizures is on; or what is most frequent as the psychic equivalent of the convulsion. The spells may be manifest in excitement, depressions, stupor, or hallucinatory state. The visional and auditory hallucinations are of a bizarre and extravagant nature. They may be terrifying, threatening, awe-inspiring, entrancing or exalting indiscriminately. Whatever obliquity has sway there is always—and this is the most characteristic thing about the deep insanities of epilepsy—a peculiar obscuration of consciousness. As regards his ability to appreciate things both objective and subjective the patient seems to exist in a realm of subliminal consciousness—a kind of somnambulistic state—in which all acts are performed in an automatic manner. If in this state he is impelled to violence ordinary human motives do not figure in his performances at all. One of these dream states may last for days at a time, during which the subject may go through movements of some intricacy, but close analysis will show that there was absence of reasoning. The acts of a person under such a spell are to be distinguished then by their purposeless and impetuous nature, lack of much complication, subconscious condition of the subject at the time and complete amnesia of what has transpired after he has emerged from the attack. The worst contingency in the premises is that epileptics who are ordinarily inoffensive and afflicted only quite rarely with convulsive seizures, sometimes suddenly develop these states and commite grave offenses. Parasthesias of great variety and intensity are frequent phenomena. This is the reason these patients so frequently strip every vestige of clothing from themselves.

TERMINAL STATES—Dr. Frederick Peterson, one of the very best informed men in this country upon these subjects, says that ten per cent. of all epileptics become insane, and that a larger number suffer dementia and other psychic degeneration after years of convulsive seizures. Mental obtundity in some measure is the rule in all the cases I have observed closely. And these patients have an abnormal facial expression, peculiar to them. It is somewhat similar to that of a paretic or dement. It must be seen often to be appreciated. One with considerable experience can diagnose a case of epilepsy with tolerable certainty upon this information, together with the tell-tale scars upon the tongue and about the body—without any knowledge of the patient's previous history. Dementia in some degree or other is the remorseless factor that pursues and finally enthralls so many of these unfortunate people whose fits have a tendency to recur frequently, and who live long enough. The status epilepticus is a common cause of death, and induces mental ablation the more rapidly.

As deep dementia supervenes the patient sinks into a helpless vegetative state.

Hemostatics.

By P. A. BOYKIN, Jeanerette, La.

Hemostatics are those agents which, when administered internally, tend to check hemorrhage.

They have a wide range of usefulness, as the average practitioner is called upon to check bleedings from numerous and varied sources.

It is a great pity that the medical world has never discovered a sure and positive hemostatic that would effectually check hemorrhages of every kind, but nothing has ever been discovered that would answer the purpose, and at times many different agents must be employed before the hemorrhage is controlled.

The hemostatics that shall be spoken of are those whose effect are upon the nervous system, and which act upon the cells of the roots of the vaso-motor and vaso-constrictor nerve centers.

Most hemostatics come from the vegetable kingdom, but some few are obtained from the animal and a very few from the mineral kingdoms.

In the vegetable class, there are ergot, digitalis, ipecac, turpentine, opium preparations, belladona, and gallic acid.

Ergot when administered acts as a vaso-motor and a hemostatic by affecting the spinal cord, circulation, respiratory organs, and intestinal and uterine fibres. Its main action depends upon producing artificial anemia of the parts and a tetanic contraction of the unstriped muscular fibres; thus having this action, it would prove useless as a hemostatic to striped muscular tissue. It also affects the Malphigian tufts of the kidneys, which is proven by the suppression of urine when large doses are given. Its action on the circulation is due to its inducing arterial anemia. Now whether this is due to direct action upon the cells supplying the muscular fibres, or whether it acts by dilating the venous system and thus causing a draining of the arteries, is yet an unsettled question; but it is known that when given in hemorrhages of lungs, kidneys, or womb, a marked effect is produced upon these organs, and especially when aided by atropin. In a hemorrhage of the lungs a good result is obtained by a hypodermic injection of ergot with one-twentieth of a grain of atropin, to be repeated at intervals of from three to four hours. In uterine hemorrhage from postpartum or other causes one-third of a grain of morphin with ergot is very efficacious, as the morphin quietens the general nervous system. In intestinal hemorrhage ergot also contracts the muscular fibres, but its action is less rapid; it is better as a prophylactic against a second hemorrhage, in case facts concerning a previous hemorrhage can be obtained. As to the action of ergot upon the hemorrhages of the brain but little reliance can be placed, as it, as well as other hemostatics, have been almost useless.

Digitalis acts by stimulating the cardiac motor, increasing the inhibitory centers and stimulating the cardiac muscle itself. When given, the first effect is to increase arterial tension, the walls becoming harder, the vibrations of heart beats more pronounced, and sometimes the number of beats diminished. A dilatation of large arteries takes place, thus enabling them to contain more blood, and the capillaries are contracted in consequence. Digitalis is useful in hemorrhage of the lungs where a number of small vessels are damaged by a caseous condition of tubercle, occasioning a frequent bringing up of blood from the lungs. In pulmonary congestion from mitral regurgitation it is excellent. In uterine hemorrhage it acts very much like ergot, but in menorrhagia and metrorrhagia, especially in plethoric subjects, it acts better. Its action upon the womb is to contract the unstriped muscular fibres, thus causing the veins and sinuses to close. In menorrhagia due to mitral regurgitation or stenosis, which interferes with the venous supply of the womb, digitalis is given continuously to relieve same. In hemorrhage of the kidneys it is contra-indicated, as it acts upon this organ in two ways, viz.: It raises the arterial tension and blood pressure to the glomeruli and it contracts the efferent vessels, while the rapidity of the renal circulation is increased and its volume augmented by the greater force of the heart beats and the dilatation of the efferent vessels.

Ipecac has but little direct action upon the blood vessels, but it dilates the cutaneous surface, thereby allowing a large amount of blood to be sent to the surface, thus relieving the large vessels of pressure and blood, and at the same time allowing them a chance to contract, as is nature's mode of self-protection where the tissue has been damaged.

Oil of turpentine has its place in hemostatics, but it is different from ergot, in that its first effect is to stimulate the vaso-motor system. This effect is rapid but is of short duration; then a temporary paralysis of the vaso-motor system takes place and the vaso-constrictor system receives the effect, thus closing down upon the small vessels and holding them in abeyance to its power; this latter effect is more lasting than the first. It is one of the best hemostatics in intestinal hemorrhage where there is much gaseous distension existing. It relieves the tympanites and at the same time causes a contraction of the bowels, and pressure is brought to bear upon the small arteries. It is seldom used in hematuria, unless as a last resort, and then its action is unsatisfactory.

Opium and its salts are used in the control of hemorrhage, and while they have no hemostatic effect, they aid materially in quieting the nervous system, which is one of the best things that can be done at such a time. The best opium preparation is morphin sulphate, and it is best used hypodermically.

Gallic and tannic acids are good hemostatics. Both are astringents, but gallic acid is more feeble in its action; yet it is better than tannic acid in remote hemorrhage. It does not coagulate the albumen of the blood and is readily taken into the circulation, either by stomach or rectum. Its effect is upon the smaller arteries, thus cutting off the great amount of blood supply and at the same time lessening the local inflammation that occurs after damage to tissue. It is used in hemorrhage of the stomach, bowels, kidneys and lungs. As to its action upon a hemorrhage of the brain, there is some doubt, but it seems as if an agent that affects the albumen of the blood as it does would necessarily have some effect upon blood clots, which always follow a hemorrhage of the brain. Gallic acid is said to have the power not only to hold blood in a liquid state, but to redissolve clotted blood. As to hemorrhages of bowels and stomach, it acts well, and in hemorrhages of the kidneys its effect is rapid, and in many instances safe when other remedies fail.

Tannic acid is found to be very powerful, but it is not as readily taken into the circulation as gallic acid, as it is too astringent and closes the way as it goes. Pyrogallic acid in one to three grain doses has some effect in hemorrhages, but it must be used with care and precaution.

There are the classes of acids and mineral salts that have a place in hemostatics, such as sulphuric and acetic acids, and copper, zinc and lead salts. These act similarly to gallic acid, but less energetically.

The animal extract of the supra-renal capsule (adrenalin), which has gained a wide reputation in the field of surgery in the arrest and control of hemorrhage, whether applied locally or internally, has the same effect. Its action is chiefly on the vaso-motor system, increasing the energy and lessening the number of heart beats, and raising the arterial tension, thus diminishing the blood supply to certain areas.

Not until there is positive proof, as to what nerves it affects principally will it be possible to class adrenalin as a specific in hemorrhages.

In conclusion, it is but correct to say that there is still much need of accurate and true hemostatics that will have their effects upon special classes of nerves that supply certain organs, and also have but one function to perform. Until this can be done it will be impossible to claim ourselves masters of the situation at all times and in all cases.

Society Proceedings.

Orleans Parish Medical Society.

President, DR. C. JEFF. MILLER. *Secretary*, DR. AMEDEE GRANGER
141 Elk Place, New Orleans.

In Charge of the Publication Committee, DR. AMEDEE GRANGER, Chairman
DRS. GEO. S. BEL and E. H. WALET.

MEETING OF FEBRUARY 10, 1906.

DR. L. PERRILLIAT reported

A Number of Interesting and Practical Cases.

(*Abstract.*)

Technical points were emphasized:

1. In the preparation of the patient before operation, the doctor reported at length the routine in use in the gynecological clinics at the Charity Hospital and illustrated by the results in his cases the uniformly good recoveries which followed.

2. The technic of the operating room, and called attention to the fact that the difference in results obtained by different operators, under identical conditions, was due to the lack of apprecia-

tion of some of certain fundamental physiological laws which govern the healing of wounds. That, above all, dry wounds healed the most kindly. That good union depended also on precise coaptation; for that reason in all operations, both in the abdomen and in the vagina, the bringing together of similar structures, as fascia to fascia, fat to fat, muscle to muscle, skin to skin, mucous membrane to mucous membrane, was conducive to the best results, by diminishing tension and interfering in the least possible degree with the nutrition of the tissues included.

3. That if the foregoing precautions have been observed the post-operative treatment will be very simple and patients will undergo the process conventionally known as an uneventful recovery.

DR. S. C. LANDAUER read a paper entitled

Some Interesting Operative Gynecological Cases.

I have been asked to present for your consideration a paper on my experiences in gynecology at the Touro Infirmary and also in my private practice; so I have selected several cases by which to illustrate my subjects.

To begin with, let us take up the most common case, the kind doctors meet daily in private practice, the consideration of pelvic peritonitis, salpingitis and oöphoritis, which follow childbirth after long intervals. Gonorrhea may or may not play a part in the causation. Here we have pain, very sharp and lancinating, situated low down in the abdomen, possibly continuous and sufficient to keep our patient confined to bed, or again it may be the dull anxiety, merely a discomfort or heavy ache, coming occasionally. This may accompany menstruation, precede it or follow it; it may show no relation and thus deceive the doctor, unless he examines very carefully. In addition to pain, there may or may not be an increase in duration of menstruation.

I have seen only recently a case where the menses lasted only one day. I operated for double tubercular oöphoritis, salpingitis and appendicitis. Leucorrhea also is a variable symptom and not to be depended on. The same can be said of fever. Unless there is pus, we may have little or no fever at all, but with a purulent collection in *cul de sac,* unless very securely walled off by adhesions, chills, fever and the general septic picture, unless early relief is afforded, are the rule.

Now, as to treatment; and right here is the point where opinions differ. What is the course to pursue? Shall we operate a patient with fever, pain and other symptoms of an acute inflammatory condition, or shall we try to alleviate symptoms, support our patient and wait for nature to come to our assistance, then, later, remove the cause?

I wish to say that, in my opinion, this condition is analogous to appendicitis and deserves similar treatment. I think the rule should be to wait until the acute stages have subsided and operate in the interim. Certainly we should be ever on the alert for symptoms demanding an immediate operation.

As for the proper treatment in the acute stage, rest, absolutely, quiet in bed in the recumbent position, which should not be altered for any purpose whatsoever, should be insisted on; ice caps and hot water bags, the former preferably, if equally bearable to patient, applied to abdomen continually and changed as often as necessary. Tampons of a 10% ichthyol in glycerin, twice daily, inserted in the vault of the vagina and kept in place by packing. Strychnia sulphate gr. 1/30 every three or four hours, to support the heart, and free liquid nourishment.

This is the treatment I am accustomed to pursue and can advise it. The bed of the patient may be raised from eighteen to twenty-four inches if there is any tendency of the peritonitis to become general. This position favors the drainage of everything to the *cul de sac.*

Elimination by kidneys or bowels, using enemas of hot water very plentifully. These hot water enemas act doubly and produce catharsis, stimulate and to some extent soothe the acutely inflamed parts.

Now, when this has been done, all that can safely be done has been performed and anything which may be harmful has not been attempted. The temperature, naturally, should be kept within safe bounds, preferably by cold sponging.

After our patient has passed the acute stage, then, and not till then, can we safely operate.

The second condition to report is another common experience to all who see a great many cases, that is ulceration of cervix and granular, warty excrescences of vagina and corresponding parts, so often seen as a result of gonorrhea.

In most instances we meet cases which answer to the ordinary treatment readily, but occasionally we meet with very stubborn protracted ones, which resist nearly all forms of treatment. To this class of cases I want to call attention and to a remedy which has given me very fine results, for the use of which I am indebted to Dr. Cocker. He had successfully treated a case of epithelioma with it, which had been tried by skin specialists for months with no results.

He had several cases of granulation tissue which $AgNo_3$ failed to relieve, but he treated successfully with this.

This remedy is the terchlorid of antimony, butter of antimony.

Literature on this is very scarce. Hare, White and Wilcox do not mention it in their text-books. It is barely mentioned in the dispensatory.

A word of caution as to its use. The parts adjacent to the diseased area should be well protected. Dr. Cocker says, in his experience, ordinary dough or putty can be moulded around, to form a fence.

Thus protecting the parts, I use vaselin just as I do when applying cantharides for blistering. If this liquid comes in contact with healthy tissue, an ugly, reddish brown ulceration results, which for some time leaves a mark; on diseased tissue, as the exuberant granulation of a tubercular sore, or the excrescences from gonorrhea, it acts nicely, causing a sloughing of old mass, and the new granulations appear more healthy and the stimulation leads to early healing. It is dispensed as an orange colored liquid and is to be kept in dark bottles, well corked.

So much for the clinical medical cases; now for the surgical ones and the first will be the tubercular case mentioned above. Here the history is negative. No T. B. C. in family and her chest was negative, nor does her past history help. Present illness began only a few weeks ago, with some little pain in back and sides, but right side especially. Tenderness over McBurney's spot. On vaginal examination made out enlargements of both sides, and advised operation.

Menses had never troubled her; of late lasted only one day.

On opening the abdomen I found the omentum and intestines both very adherent to the seat of the disease and they were with difficulty released, after free use of catgut and scissors. The adhesions were so broad and tough that I could not tear them at all.

After I freed the intestines and omentum, the first thing to which my attention was drawn was an elongated body attached to the fundus of uterus by fine adhesion. This proved to be the appendix, the tip of which was curled on itself.

It was seven inches long and as large as the little finger. I took it out, used the cautery, inverted the stump and sutured the bowel, as ordinarily done. I found both tubes to be enlarged about the size of a thumb and the ovaries to the size of a hen's egg, cystic and very much adherent. On the left side was an accessory tube, 2 to 2½ inches long, also enlarged and adherent and situated just beneath the first one. I grasped the uterus with a large pair of four pointed tenacular forceps and by using traction with one hand and breaking up adhesions with the other, managed to free the uterus enough to get it up to enable me to tie off tubes, and with one free end quickly took out the mass from both sides, after using catgut and scissors freely. On opening the specimen, a thick, brownish, tenacious, cheesy material escaped. No tubercle bacilli were found in it, but it was pronounced tubercular. She made a good recovery.

The second case is interesting, inasmuch as it presents a complication of complete collapse of the uterus, with partial inversion of the fundus, reaching nearly to external os. The patient was a mulatress, fifty-one years old, mother of five children, oldest thirty years old, youngest twenty-two. She was always well. Labors all easy, without complications. Had passed meno-pause two years ago. Present troubles began nearly a year ago by pains in lower abdomen, not very severe, but in a short time they were followed by the appearance of what she called the tumor, which gradually became larger and larger, and though uncomfortable, was not especially painful. She experienced hemorrhages and leucorrhea, but not severe enough to confine her to bed. Of late, she had some pain, caused by ulceration of the cervix from contact with the clothes. For this she sought advice. The uterus was very much enlarged, totally prolapsed, softened and bled very easily. After an effort, succeeded in reducing the prolapse and then could note easily the depression where the fundus should have been, the correctness of which was easily done by dilation of the cervix and pressure with two fingers in the os. Then curetted and packed uterus with iodoform gauze and did a ventral fixation, though the treatment should have been a complete hysterectomy had her condition permitted. Now, twelve days since the operation, she is doing nicely.

As to the explanation of this case, the same thing which caused the prolapse caused the inversion, and that was endometritis, hypertrophica chronica, which not alone caused enlargement, but softening as well. And to this add a severe tear of perineum and you can easily satisfy yourself as to the causation. It is interesting to note the time from last childbirth to the time of her first symptoms, namely, twenty-one years.

Another case which came under my observation about two years ago, a woman aged sixty, virgin, consulted me for total collapse of several months' duration. Hymen intact, but in spite of that the uterus protruded completely, but was easily reducible. Menses had always been regular without pain, but they had ceased four or five years previous. Bowels regular; no pains or troubles of any kind, except this. This trouble came on gradually and had slowly increased in size. On examination, found a large left ovarian cyst. Operation was advised. The cyst was removed, a ventral fixation done and woman made good recovery, but last week she returned, the uterus having prolapsed again. At first, we accounted for the condition by the ovarian cyst, but now can find no reason for the relapse. I am now trying to hold up uterus with ring.

DISCUSSION.

DR. MILLER: The indications for Alexander operation are mild retrodisplacements uteri without disease of the adnexa. Within the last two or three years this operation has been done more frequently. It had fallen into disuse because at first it was not limited to the proper cases. Now the results are much better.

Cases of dysmenorrhea due to small adhesions or bands are not relieved by the Alexander operation. The principal contraindications to the Alexander operation are cases of dysmenorrhea of long standing and cases in which fever exists during menstruation. He agreed with Dr. Perrilliat that a dry field of operation gives the best results, especially in vaginal work, and he usually packs the vagina with iodoform gauze for about four days, for, as a rule, there is very little exudate before that time.

Dr. Walet recently saw a patient upon whom the Alexander operation had been performed, with too great shortening of the round ligaments, thus bringing the fundus of the uterus abnormally near the symphisis pubis.

Dr. Perrilliat: In one case he failed to find the round ligament and he believed it would be interesting to the members to know the cause of such failure, as explained by Dr. Bayon. The latter had told him that the round ligament entered the inguinal canal at the internal inguinal ring and usually divided into its fibres of insertion about the lower part of the canal; but it sometimes happens that at the internal ring it splits up into numerous fibres, which spread out to join the aponeurosis of the external oblique and becomes inserted with it into the symphisis. Of course, in the latter case, the ligament cannot be found in the canal, for it has lost its entity, and only separate minute fibres are present.

Dr. Lowe asked Dr. Perrilliat if menstruation, occurring twice a month in one of the cases reported by the doctor tonight, was not abnormal?

Dr. Perrilliat, in answer to Dr. Lowe, said that what his patient had had was not the menstruation, but irregular hemorrhages.

Dr. Landauer dwelt at length upon the case of peritonitis which he had reported tonight, because it was only after holding a consultation with three other physicians that the last only agreed with him that no operation was immediately necessary, the others concluding it was, and the patient was left alone until later on, when her appendix and right ovary and tube were removed, the other ovary and tube being left undisturbed.

RELATION OF CASES.

Dr. Dabney related a case of *Acute Alcoholic Poisoning in a Child Three Years Old.*—When the doctor saw this little patient, possibly one hour or two after the ingestion of the alcohol, he found her in a comatose condition, her whole body cold as marble, her heart action so feeble that the pulse could not be felt in the extremity. The parents had discovered just before he came that the child must have drank over a pint of whiskey from a bottle which had been left in their bedroom. The most interesting feature of the case was the fact that although he held the child so close to a fire that his hands could not stand the heat no warmth was imparted to the child's body, which remained pale and cold as if made of stone. With careful watching, warm frictions and the hypodermic injections of small doses of strychnin sulphate, the baby made a complete recovery after twenty-four hours.

Dr. LeBeuf: What time elapsed between the time the child swallowed the alcohol and the time that the doctor had washed out the stomach?

Dr. Dabney was certain that over one hour had elapsed.

Dr. LeBeuf reported a case of *Sloughing Due to the Hypodermic Injection of Eucain.*—The doctor employed a solution of eucain as a local anesthetic in a case of circumcision. All antiseptic precautions had been taken and the line of suture healed by first intention. The sloughing which took place was at the site of puncture by the hypodermic needle used in the injection. Several similar cases have been recorded in recent French literature, and he knows of at least two more cases which were reported in this city.

Dr. Miller: May not the sloughing have been due to some impurity in the solution and not to eucain? He was on the point of using once a Schleich's solution for general anesthesia, instead of Schleich's solution of cocain which had been prescribed, by mistake of a druggist, in which there was some benzine, and he knows that this would have caused some sloughing had he used it.

Dr. Chavigny related a case of *Successful Operation for Carcinoma of the Cervix.*—Mrs. H., white, aged thirty-one, mother of one child three years previous to the appearance of tissue. Patient first consulted him four years ago, complaining of a slight bloody discharge; no pains. Examination revealed an ulcerated condition of the anterior lip of cervix, slightly to the left. There was no odor, which is so characteristic. Local application of 10% argyrol solution for three weeks did not improve the condition, which steadily grew worse. He advised operation after two positive microscopical examinations of the tissue, at different times, were made. Vaginal hysterectomy was advised and performed in February, 1902, from which the patient made an uneventful recovery. She then left for her home in Chicago. He did not see her until February of this year (1906), when she called at his office. Examination showed no evidences of any ulceration whatsoever. His object in reporting this case is to add one more case to the list of cured cases, brought about only by an early recognition of the disease, which is the only secret of success in the operative treatment of carcinoma of the cervix.

Dr. Marcour reported *A Case of Sprue, or Psilosis.*—He was called to see a young married woman, twenty-four years, pregnant about three months, who had been living in Honduras and had been suffering for some time with a severe diarrhea and fever. Previously her mother had consulted a physician of this city about her and he advised her to change climate, as she was probably suffering with dysentery. At that time the stools averaged five to ten a day. Upon her arrival in the city she was placed on salol and ipecac, and after eight or ten days was discharged, apparently cured. Two weeks later, Dr. Marcour was called back to see her and found her suffering from what he diagnosed as remittent fever, which, although yellow fever was prevailing at the time, could not have been the latter, as she was an immune, having had the fever in 1897. There was albumin in the urine and large doses of quinin had little or no effect on the fever at first, but later seemed to control it. The stools became very frequent, forty to fifty a day; there was no blood in them at any time.

The doctor had to leave the city and left her in the care of Dr. Troescher. The latter, at the family's request, had to see her in consultation with two other confreres. At one of these consultations the diagnosis of abscess of the liver was made, but was not confirmed after several punctures. A diagnosis of typhoid fever was then made, but Widal's reaction was negative. It was then thought that the patient's condition was due to anemia.

The next diagnosis made was that of syphilis. It was made by one of the physicians in consultation, he having treated the patient's husband, prior to his marriage, for the disease. The patient miscarried at seven months. The fetus remained alive for several hours and gave absolutely no evidence of syphilitic taint.

On Dr. Marcour's return to the city the patient was unimproved, very much weakened, emaciated, the frequent mucous stools persisting, albuminuria 10% to 15% moist albumen, and edema of different parts of the body. The face and neck were considerably swollen. On close examination, a peculiar and characteristic condition of the tongue, the fungiform papillæ standing out prominently, like warts, while the filliform papillæ could not be seen. There were ulcers in the throat. This condition suggested the disease called psilosis. The patient asked continually that the little wart on her tongue be cut away.

All previous treatment was stopped and the patient put on a strictly milk diet and given lemon juice freely. This soon caused a cast to come away from the tongue and in a few days the patient began to improve. The milk was pushed to one and one-half gallons a day, the stools had been examined for ova, and as none were found, the case was not one of uncinariasis. The amount of albumin and the edema persisted a long time after the patient miscarried and until the milk diet had been instituted.

DISCUSSION.

Dr. Troescher saw this patient during Dr. Marcour's absence and afterwards, during her convalescence. He could testify both as to the gravity of the case, the seriousness of the symptoms and the excellent results of the milk diet and lemon juice.

Dr. Bass: Were the stools dysenteric or merely frequent mucous stools? What was the diagnosis based on?

Dr. Marcour, in answer to Dr. Bass, said that the stools were not dysenteric. The cardinal points in making the diagnosis are the condition of the tongue and mouth, ulcers in the throat, the condition of the stools, fever and emaciation.

MEETING FEBRUARY 24, 1906.

DR. E. D. MARTIN read the following

Report of Committee on Result of the Suit of E. Denegre Martin vs. Nicholson Publishing Co., Ltd.

Gentlemen of the Orleans Parish Medical Society:

It affords us great pleasure to report to you that, as a result of this suit, the Supreme Court of Louisiana did on the 2d day of January, 1906, declare that as the article published by the New Orleans *Picayune* on July 2, 1904, was unethical and therefore contrary to the desires and wishes of plaintiff, and as the *Picayune* had been notified to this effect previous to its publication, it could not, as the lower court had ruled, be decided on an exception of no cause of action. "It is therefore adjudged and decreed that the judgment in this case is annulled, avoided and reversed; the exception of no cause of action is overruled; that the case be tried in accordance with the views before expressed. Appellee to pay the cost of appeal and those of the District Court to await the final determination of the suit." The ruling of the Supreme Court means just this, that if at any time the case of a physician or surgeon is reported in the lay press without his knowledge or consent, he has only to prove that this class of advertisement has injured his professional standing and to what extent and he will be reimbursed for the loss. Nor is this all. The Associated Press, soon after the decision of the Supreme Court, issued an order forbidding the publication of stories or reports of cases in which the name of the physician was mentioned.

And what does it all mean? It means that at least the medical profession has found a means to stamp out an evil which was fast gaining ground, not only here but all over the country. We have now only to make such offenses committed by members of regularly organized medical associations punishable by expulsion. If these members are guiltless, they will have redress in the courts and can be re-elected to membership when they have proven their innocence; if guilty, the punishment will be well merited.

To better understand the causes which led to this suit, we must go back to the visit of Dr. Lorenz to this city during the meeting of the American Medical Association in 1903. At that time his visit was heralded by all of the papers, as his work on congenital dislocation of the hip was new to most of the profession as well as the public. His clinics at the hospital were reported daily. Nor did it stop there. Some of the local surgeons were fortunate enough to secure a few cases after his departure, and the results of these were eagerly sought after by reporters and published in the lay press. Material was scarce, however, and soon these reporters were forced to seek cases in other fields, and so successful were they and so frequently did these articles appear in the daily press, that at the meeting of May 28, 1904, the following resolution suggested by Dr. Gessner was passed: "Be it resolved, That it is the sense of the Orleans Parish Medical Society, that it is inconsistent with the highest ideals of the medical profession for members to permit the appearance in the daily press of articles bearing on their personal attainments or accomplishments."

DR. KOHNKE moved that the resolution be sent to the papers for publication.

Carried.

At the meeting of June 11, 1904, the following resolution, offered by Dr. Magruder, was passed: "Whereas, The frequent appearance in the daily papers of articles dealing with the professional attainments of members of this Society would seem to indicate a growing disregard for medical ethics:

"Be it resolved, That copies of all articles appearing in the daily press of this city, relating to such cases, be kept in a scrap-book, which shall be kept on the President's desk for the inspection of members. The book shall be indexed, and any member whose name shall appear therein will have the privilege of attaching thereto a written explanation.

"Resolved, That a copy of this resolution be sent to each member of this Society.

"Resolved further, That a committee of three be appointed by the chair to visit the papers, present the resolution, and at the same time impress upon the public press the views entertained by this Society upon the subject."

In accordance with this resolution, Drs. Kohnke, Gordon King and E. D. Martin were appointed a committee. They carried out the instructions of the association to the letter, calling on the managing editors of the papers on June 24, 1905.

It happened at this time that Dr. Martin had under treatment a young lady, twenty-two years old, who at the age of five had had the head of the left femur removed, as the result of tubercular infection. This was not the sole cause of her trouble, for she suffered with every possible complication, and just two months before he had removed her appendix. She was so much improved as a result, that for the first time in many years she was able to leave her bed. You may imagine his surprise, not to say indignation, when on July 2, 1904, and only eight days after the committee's visit to the papers, his attention was called to the following publication in the *Picayune:*

"DR. LORENZ'S METHOD TRIED ON YOUNG LADY HERE WITH REMARKABLE SUCCESS.

"Seventeen years an invalid from congenital hip disease and now able to walk with the aid of crutches, is the record of Miss Sadie Marx's long trial. She is the daughter of Louis Marx, of Carondelet and Louisiana avenue, and when she was four (4) years of age, she developed a dislocation of the hip. From that time on the ailment rapidly grew worse, and seventeen years ago she became an invalid, but now she has practically recovered the full use of her hips, and is on the fair road to permanent recovery.

"Miss Marx's case is unique, and probably without parallel in the medical practice in this State. Different surgeons tried their skill on the affected limb without bringing permanent relief, and eleven years ago she was put under the treatment of Dr. E. Denegre Martin, of this city. He treated her continually, including several operations, which he found necessary to furnish relief from the dislocated femur.

"When Dr. Lorenz, the celebrated bloodless surgeon, visited New Orleans and demonstrated on local patients, Dr. Martin made a close study of the work of the celebrated specialist, and in a short time Miss Marx was undergoing a treatment in bloodless surgery. However, Dr. Martin continued his former applications, and with the aid of Dr. Lorenz's methods she began to show signs of improvement. Three weeks ago she was able to get out of bed, and last evening she visited several friends, in company with her father, who is jubilant over what he considers a permanent cure.

" 'My daughter was a confirmed invalid for seventeen years,' declared Mr. Marx last night, 'but now she can get about without trouble, and will no doubt soon get well under Dr. Martin's masterful treatment. He has done her immense good, taking her from an invalid's bed and putting her in a condition where she can get about and call on the relatives and friends who visited her while she was in bed helpless. To look at her now no person would ever believe that she spent all but four years of her life on the broad of her back.'

"It was also stated by the proud father that his daughter was not only troubled with congenital hip disease, but she survived an operation for appendicitis last fall. Before that her hands were almost useless through rheumatism, but she soon got over that, and all that affects her at present is a slight limp, which necessitates her using crutches. Mr. Marx is confident that the supporters will be thrown aside in a short time, and his daughter able to walk unimpeded."

Dr. Martin reports that he called at once on Mr. Rapier, of the *Picayune,* but not finding him in his office, consulted Mr. J. Blanc Monroe, of the firm of Lapeyre, Monroe & Breazeale, who called on the attorneys of the two papers, the *Picayune* and the *States,* which had published the article, and his attorney reported that it was intimated that in the event suit was brought the columns of the paper would be used in discrediting the standing of the complainant and the position taken by the association. With this threat, Dr. Martin determined at once to take the matter into the courts.

It does not seem amiss to mention here that this publication afforded much amusement to the friends of Dr. Martin, especially as they knew the history of his patient and the absurdity of the publication. Furthermore, it was pasted in the scrap-book in accordance with the resolution.

The case was first tried in Section C, Civil District Court, before Judge St. Paul, who held that, as the article was complimentary and no malice was shown, there was no cause of action. This decision was not unexpected and it was then taken to the Supreme Court, with the result as above stated.

Having won a decision so far-reaching and accomplishing all that could possibly be desired, it was mutually agreed between the attorneys of both sides that the *Picayune* would pay the cost of Court according to the decision of the Supreme Court and that the matter would end here, as the continuance of the suit would only decide the extent of injury and the amount of damages involved, and we are free to say that this part of the proceedings was introduced into the suit, because form required it, for under no circumstances would Dr. Martin have accepted one cent, for morally he felt that he had not been personally damaged, but the opportunity of testing the liberty of the press and of stopping the publication of the objectionable articles presented itself and he felt that if something could be accomplished your committee would have done well. The committee is satisfied that the publication, the subject of the suit. was not the result of any intention or desire on the part of the *Picayune* to oppose the resolutions of the Society, presented by your committee to the managing editor.

Having performed their duty, the committee now ask to be discharged.

Q. Kohnke,
Gordon King,
E. D. Martin.

Discussion.

Dr. H. P. Jones asked Dr. Martin what was the effect of the decision of the court on the press of the State and country?

In answer, Dr. Martin read from the report the decision of the Supreme Court of the State of Louisiana.

Dr. Parham thought that Dr. Martin was to be congratulated on his persistence, in the face of almost universal condemnation, in continuing the suit, which had thus finally won such a decision from the highest court of the State. Many lawyers of prominence had pronounced the suit ridiculous, without the shadow of a chance of success.

DR. KEITZ felt especially gratified at the success obtained by Dr. Martin, because several years ago he was placed in a very embarrassing position by the publication in the *Daily News* of a glaring article about his professional exploits. The first that he knew of the article was when a patient brought him a bottle of urine wrapped in the offending paper. He moved that a vote of thanks be tendered to Dr. Martin for having settled this vexing point.

DR. MARTIN, in closing the discussion, said that he had persisted in his suit principally because the *Picayune* had intimated that if he did so it would "do him up" professionally. The decision of the Supreme Court is far-reaching, and the Associated Press immediately afterwards issued an order prohibiting the printing of all articles either on or about physicians. It merely means, therefore, that from now on no paper will publish an article about a physician without his knowledge and consent.

DR. PARHAM, referring to that part of the report read by Dr. Martin which stated that he had suggested the resolution establishing the scrap-book, etc., wished to disclaim any relation with either the establishing or discontinuance of same. He had merely remarked to Dr. Magruder, then President, that a plan which had been successfully employed by the Colorado Medical Society to prevent doctors from rushing into print was the keeping of a scrapbook in which everything published in a newspaper about a doctor was pasted. He was not even present at the meeting at which this suggestion of Dr. Magruder's was adopted.

DR. H. P. JONES read a paper entitled

A Brief Summary of All the Work Done in the Two Emergency Hospitals Under My Control.

The first hospital site, a building No. 521 Dumaine street, was selected by the city authorities, municipal and health, as being the most suitable available place in the center of the original infected area.

This building, vacant at the time, but formerly used as an Italian boarding house, prior to which it was used as a residence and seed store, was vacated on account of poor ventilation and great heat during the warm weather. This building was forcibly taken for this purpose by expropriation. It was in the logical spot for a yellow fever hospital and no fault attaches to anyone for not foreseeing the grave sanitary inadequacies of the building, which were developed and discovered after occupancy by us. These inadequacies, so serious and intolerable, necessitated the abandonment of it and the establishment of a new hospital under the direction of Dr. White, the McDonough Public School Building No. 18, secured for this use through the Mayor, Mr. Martin Behrman, the School Board and the courtesy of the Frisco railroad officials.

The history of the opening of the yellow fever campaign is too well known to take up now, so I will only mention those under whom I labored directly in the establishment and maintenance of the Dumaine Street Hospital. They are Hon. Martin Behrman, mayor of the city of New Orleans; Dr. Quitman Kohnke, President of the City Board of Health; Dr. Paul Michinard and Dr. Arthur Weber, of the same Board; Dr. L. G. LeBeuf, of the Advisory Committee of the Orleans Parish Medical Association; Dr. Callan, and Mr. Gus Lehman, Sr., of the Citizens' Finance Committee, and to them is due any credit that may have been earned by the establishment of this hospital, which was of a most positive value in the fight so successfully brought to a close by the Marine Hospital officers. Drs. Michinard, LeBeuf and Weber and Mr. Lehmann, comprising the Hospital Committee, visited the chosen hospital site with me on the morning of the 26th of July, it being the first time some of us had ever seen the building, and at once set to work converting the empty building into a hospital for the care of yellow fever, according to lines laid down by the accepted mosquito theory. Suffice it to say, that work was pushed with such vigor that the building was safely screened, lighted and equipped, and the hospital force so organized that on the evening of the second day, thirty-six hours after the work was started, patients were admitted and cared for.

The staff consisted of myself as resident and executive physician, Dr. Chas. Faget, resident physician; Dr. P. E. Archinard, pathologist; Mr. Thos. Lanaux, resident medical student in charge of ambulance, and Mr. Lewis H. Marks, medical student, superintendent. About August 3, owing to an illness of Dr. Faget, Dr. J. B. Guthrie was added to the resident staff.

The first trained nurses available were employed, and everything that modern science and experience could suggest and ample means could purchase was afforded the patients. A horse and screened ambulance were purchased and used, while the sanitary condition of the building was ameliorated as far as possible by improving the plumbing and sewerage, numbers of electric fans were employed to improve the ventilation, and relieve the hospital of some of the vitiated air; at the suggestion of Dr. Michinard large air-shafts were cut from floor to floor and thence to roof, with rotary electric fans within them; all fans were kept going night and day, but, in spite of all this, the heat was unbearable, and the air was bad to an extent detrimental not only to the lives of the sick, but also to those under whose care they were. All surrounding walls were fire-walls, without openings, except on Dumaine street, and even in the rear the walls were solid brick and not less than twenty-five (25) feet high, so that practically the only means of fresh air supply were afforded by the twelve openings in the front of the building facing on Dumaine street. The problem of ventilation was rendered more difficult by the use of mosquito bars instead of wire screening. This was used, because no wire cloth measuring less than sixteen (16) mesh to the inch could be procured at that time, and not even enough of that to screen the building. Owing to the presence of a large number of cats in the neighborhood, who seemed to like to stretch their claws on the netting in the windows from the outside, it was necessary to double screen most of the windows. On account of a fear of possible faults in the screening, mosquito bars were also kept over the beds. And, as the space in the building did not permit of a long entrance vestibule with doors so arranged that only one of the double doors could be opened at one time, the doors entering the wards from the halls were also screened.

Great difficulty was experienced at first in securing a laundry to do the work, but subsequently I was so fortunate as to secure the services of the Sisters of the Holy Family for this purpose, and, with the exception of the first two weeks' washing, all articles of linen, soiled in the hospital, were taken without disinfection to their Convent, situated on the corner of Orleans and Royal streets, and washed.

It is worthy of note that their Convent was one of the few public institutions to escape the fever entirely. Particular care had to be exercised, however, to see that no mosquitoes were brought into the hospitals, either in clothes, hampers or in packages of any character, as on several occasions, on inspection, mosquitoes were found therein. It was the custom to have these inspections made of all packages.

The hospital on Dumaine street had a capacity of about eighty (80) patients. In the establishment of the new hospital, it was deemed advisable to have the equipment of such a character that it could be used in any permanent hospital that might subsequently be erected, so that specially designed beds, to the number of one hundred (100), were made to order, and everything necessary to the equipment of a first-class medical hospital was secured of the best and most substantial character.

The new hospital was equipped throughout with electric lights and ceiling fans, which were a great advantage over the noisy rotary "buzzers" used on Dumaine street.

Ventilation in the new hospital was naturally fine, and the air was always pure and sweet. The building having one hundred and fifty (150) openings as against twenty-four (24) in Dumaine street, it was seldom necessary to use artificial light in the new hospital during the day, while in some of the wards on Dumaine street artificial light was constantly necessary.

From the outset there was very strong local opposition to the Dumaine street hospital, owing to ignorance, prejudice and the large business interests in the vicinity, especially of those dependent on the market trade.

It did not take long, however, to teach the foreigners, who comprised by far the greater proportion of our cases, that the hospital was not only run for the city's protection, but for their own good, care and benefit, so that those actually sick and their families got over their fear and prejudice long before the business men of the vicinity. I found the Italian immigrants, no matter how ignorant, were the most docile and amenable, and quick to appreciate the value of the hospital of all the foreigners.

Appended is a compilation of the records of the cases treated, of whom two hundred and fourteen (214) were cared for in the old hospital, and one hundred and thirty-nine (139) in the new.

The mortality rate in the old one being nearly twenty-eight (28%) per cent., while that in the new was less than seventeen (17%) per cent.

At this juncture I wish to draw particular attention to some points that seem to be worthy of note.

Most important, aside from mosquito protection, in the building of a permanent hospital or the selecting of a temporary site, should be the lightness and airiness of the walls and rooms. A considerable sacrifice should be made to insure this, and an air of cleanliness and cheerfulness. The difference was manifest in the varying death rates in the different wards in the Isolation Hospital on Canal street in 1897—and in the death rates of the old and new Emergency Hospitals the past summer. Dark and sombre surroundings depress and agitate by frightening the sick, while well-lighted, clean and cheerful wards, by giving a sense of interest and care in all things, produce an effect of security and tranquillity of the greatest importance in the management and treatment of yellow fever.

In the new hospital wild delirium, necessitating humane restraint, was very rare, while in the gloomy and sombre wards of the old place, delirium of the most violent character was very common, and its effects most disastrous. Screens should be so fixed that they will keep a man from jumping out of a window, but should not be so barred as to give a jail-like feeling to any inmate.

There is no disease in which good light, ventilation and cheerfulness pay such a handsome reward in lives saved, and so promptly and palpably, as in yellow fever.

Another point of great practical value, from a diagnostic standpoint, is the color of the walls and window shades. No color should be used that will prevent the easy recognition of jaundice.

The details of screening are of practical importance, and, in the appended drawings, an attempt has been made to bring them out. The three door vestibule and single entrance and exit idea was excellent, only where the whole mosquito defense depends on the outside screening no entrance or exit should open into any main portion of the building directly, but always through an office or cloak room.

The type of fever during the summer of 1905 seemed to be very much more severe than in 1897, or that seen by men in Cuba in 1898, and the comparatively higher death rate of the Emergency Hospitals may be in part due to this fact, but the higher death rate is, in a great measure, due to the much greater proportion of newly arrived foreigners in 1905, and lastly to a more accurate diagnosis of the cases, by the thorough utilization of all the clinical aids to diagnosis at our command, including a most excellently equipped and administered clinical laboratory, and too much credit cannot be given to this department for the work therein.

While these hospitals were conducted as sanitary and prophylactic institutions, no oportunity for scientific research was lost, and all necessary and reasonable instruments and equipment were furnished. And, in fact, I did all that I could to facilitate the clinical and scientific study of the disease, not only by our staff, but also by Drs. Rosenau and Goldberger, of the United States Public Health and Marine Hospital Service, for whom a special laboratory was fitted up and every facility tendered them in the prosecution of their work. The wards were at all times open to the profession, and their visits were always welcomed and encouraged. The friends and relatives of patients were encouraged to come at certain visiting hours, and several thousands must have availed themselves of this privilege, most of whom were non-immune. No importance was attached, in the employment of nurses or help, to the fact of their being immune or non-immune. Of the immense number of visitors and the large number of non-immune nurses and help employed, only one case, that of a nurse, developed, and that was almost positively traced to an outside source. It was not convenient and we did not have the facilities to provide for a nurses' dormitory, so all nurses returned to their homes after work was over.

Danger of fire was a great source of anxiety, especially on Dumaine street, and ample provision against this emergency was secured by the purchase of a number of hand-grenades and extinguishers.

More careful clinical records were kept of the cases than have ever before been kept in a similar series of cases of yellow fever, and these records, with all personal and other bedside notes, are to be found at the disposal of the medical profession and under the care of the Orleans Parish Medical Society.

In having charge of these two hospitals, I endeavored to realize and materialize the fact that they were not only hospitals in the true sense of the word, but were also great public object lessons, tangible and observable, with a mission to teach the rational way to control the spread of yellow fever. Not one of the twenty-seven cases suffering from various other diseases contracted yellow fever.

A fact of the greatest commercial importance to this community and to the transportation companies, and which established beyond the shadow of a doubt the value of a properly constructed and conducted Isolation Hospital, was that the free taking into the hospital of a large number of cases from outside of this city in no way endangered this community, or influenced the ultimate control of the situation in New Orleans.

In some instances, this removal of cases removed the danger of infection of the outside community and united railroads.

DISCUSSION.

DR. LAZARD mentioned the fact that the records of the Emergency Hospital form a part of the general records of the campaign of 1905. The latter would furnish, besides other information, the ages and nationalities of the cases of and deaths from yellow fever during 1905.

DR. CHASSAIGNAC did not wish to controvert the correctness of the deduction that yellow fever patients do very much better when treated in cheerful and well-lighted quarters than in sombre ones, but we should not compare too closely the mortality rates at the two hospitals. It is a recognized fact that the highest mortality is usually comparatively early in epidemics, and that not only the number of cases, but their virulence, seems to go on diminishing after a time. We must also make due allowance for the difference in the class of patients treated in the two hospitals.

DR. LINDSEY, of Nashville, a guest of the Society, said that the mortality among cases of yellow fever treated at home in later epidemics never exceeded 10%, while in hospitals it was never under 25%. He did not believe that these cases should ever be moved out of their homes, more especially after the third day.

Dr. Kohnke said that in the earlier days of the epidemic here the patients were moved to the hospital from very poor surroundings and practically no treatment at home; he believed that was the cause of the higher mortality in hospital as compared with that for patients who had good surroundings and good treatment at their own homes. He also believed that the mortality among patients who were sent to the hospital was less than it would have been if those same patients had been treated in their homes.

Dr. Lazard said that almost 40% of the deaths in yellow fever occur after the fifth day of the disease. Patients that are brought to the hospitals on or after that date of the onset of the fever are almost moribund. The general mortality in 1905 was a trifle over 13%. The mortality among the native-born Italians was much greater than that.

Dr. H. P. Jones stated that the surroundings were not entirely responsible for the issue. The first cases of the fever in 1905 were mostly Italians recently arrived from Italy, and the majority of these had been sick a number of days before they were brought to the hospital. The high mortality was not due alone to the surroundings but to the temperament of these patients, their short time in the city, etc. The hospital on Dumaine street did the brunt of the work, and although it was a very poor place for a hospital and had been very hurriedly fitted up, it was the best that could be had at the time, and was situated in the most rational locality.

Dr. Dempsey brought out the point made by Dr. Lindsey that patients should not be moved after the third day. He wanted to know from Dr. Jones how long after admission to the hospital death took place, when it did occur, in patients who had been moved after the third day of illness. Also, what proportion of those patients died?

Dr. Jones, in answer to Dr. Dempsey, stated that whether moving or some other reason was the cause for the difference between deaths in hospitals and in homes, the moving of those patients to the hospitals was always done either for the good of the patient or the good of the many.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

Once More the Mosquito.

It may be interesting, perhaps also useful, to reproduce in part an editorial which appeared in this Journal about two years ago. We do not care to say "we told you so," but if our suggestions and even pleadings had been heeded our Southland would have been spared a good deal last summer and we would at present be relieved of a good deal of anxiety.

Here is what we said in 1904, and which referred to previous efforts on our part to enlist the interest of the medical profession in this subject:

"Future generations at least will appreciate that the JOURNAL has done all in its power to foster scientific research concerning the pests, and to stimulate systematic efforts to destroy them. From the time of publication of the praiseworthy studies undertaken under the auspices of the Orleans Parish Medical Society (1901), we have on numerous occasions referred to the subject, both from the purely scientific and the essentially utilitarian side.

"Deeming the subject of sufficient importance, we feel it our duty to call attention to it over and over again. Should we succeed in impressing the medical profession, they in turn would find the way to influence the public.

"Can you not, confrères, make your constituents realize what a nuisance mosquitoes are simply as enemies to their comfort; how costly they are from the work lost and the expense caused by the malaria they propagate; what a serious menace to the lives of loved ones and to commerce and progress from the yellow fever they disseminate? Surely it would only be necessary to make the people see and feel all this in order to spur them to intelligent action.

"Regarded merely as a form of insurance against much physical discomfort, loss of labor, paralysis of business, inhibition of progress, and sacrifice of human life through a preventable cause, the expenditure of a large fund for the destruction or mitigation of the mosquito evil would prove a good investment."

In line with the above and as a timely suggestion, perhaps even more so than at the time it was originally written, we reproduce almost in its entirety a short editorial which appeared in the pages of this publication in August, 1904:

> "It may not be amiss to remind our readers that at all times, and particularly at this season, it would be well to insist that all fever patients be guarded against mosquitoes by means of screens and good mosquito bars.
>
> "The comfort alone of the fever stricken unfortunates demands that due care be taken to protect them. Yet we know that this point is frequently overlooked; if not, that the repeated raising of the bar finally admits a number of mosquitoes, who miss no opportunity to sneak in. Hence, in houses that are not wire-screened, the beds of fever patients should be protected carefully by means of bars of bobinet or other suitable and cheap material. The expenditure of time and money would be trifling, still no one can calculate how much benefit would accrue from the habitual observance of these precautions—certainly a vast amount."

The Walter Reed Memorial.

Our attention has been called to the fact that of the $25,000 which are needed for the Reed Memorial only about $16,000 have been subscribed. The largest number of contributors are of the medical profession, but up to this writing Louisiana has only contributed $50, and Texas $60. It is unnecessary to remind the profession of what Dr. Reed accomplished in relation to the propagation of yellow fever by the mosquito, nor of the enormous advantage to humanity which will result; neither that our Southern States are apt to be those most benefited and that the great work done here last summer was made possible at that time only through the labors of Reed.

We hope it will be necessary only to remind the profession of the purpose in view by the Committee in charge of the Memorial Fund, which is twofold, viz.: to assist by means of the interest on the fund in increasing the income of Major Reed's widow during her lifetime and later to build a permanent memorial in the city of Washington. We are satisfied that a sufficient number of the profession will be glad of the opportunity to contribute, and the

JOURNAL will be glad to forward any amounts entrusted to its care, together with its own contribution. Those preferring to do so may correspond directly with Gen. C. DeWitt, secretary of the Association, whose address is Washington, D. C.

The Public Health.

The Pure Food Bill has become an act and a fact. Already the Bureau of Chemistry of the Agricultural Department is busy with infractions of the law. Our Teutonic and Gallic cousins have appreciated the mighty arm of authorized investigation of their multicolored products and the fruits of the prolonged struggles for purity are being born each day.

A few years back and the general public was far from ready to have their health supervised by a paternal government. Even within the several States themselves any show of legislative enactment directed at regulating food products, drug dispensing, or even the practice of medicine, was promptly cried down as politics for partisan protection. The seeds of education have steadily gone on to a fructive usefulness, until today the people themselves are demanding protection.

The far-reaching influences of even such an act as the Pure Food Bill will bring other acts in train and soon the Public Health will be a matter of course.

It is regrettable that there should be any such division of opinion in the United States Senate over the quarantine bill—for this means simply a postponement of an inevitable outcome of the matter, for some uniformity must prevail. Meantime we must congratulate ourselves as medical men that the profession we represent has gradually attained the good results hinted at above. The constant discovery that the greater part of the civilized world is victimized and in large part murdered through commercialism in food and in drugs and that the medical profession has always warned against these things must argue a humanitarian practice on their part.

But we must see to it that as time goes on the general tone of the public must improve with the added education.

The political economist still figures out the square acreage of the universe in its relation to vital statistics, and the human temper, Providence and Darwinian law all help to prove the sinister doctrine of supply and demand. Death is inevitable, but in a saner sense *"dum vivimus, vivamus."* With improved dairy methods, cleaner households, sanitary conveniences for public use, clean streets and the constant war upon fraudulent foods, our environment must argue for a healthier life.

Metchnikoff, meantime, is making the way for us to enjoy immunity against old age, and in one or two generations, *sans* appendix, with a diminutive larger intestine, we may hope to sit patiently in perpetual peace, waiting for the accident which is to remove us from this sphere.

Meanwhile we have the right to reflect in ratiocination and to applaud from our seat in the rostrum at the achievements of those who have fought, who are fighting and who will fight for the purity of the public health, on every side.

Abstracts, Extracts and Miscellany.

Department of Obstetrics and Gynecology.

In Charge of Dr. P. Michinard and Dr. C. J. Miller, of New Orleans.

Sudden Death During or Immediately After the Termination of Pregnancy, and Operations on the Pelvic Organs in Women.—Davis (*Surg., Gynec. and Obst.*) reports 3 cases of sudden death, 1 after abortion, 1 after delivery by forceps, and 1 after hysterectomy with the removal of the tubes and ovaries. The case of abortion had been criminal, and the patient was seen in consultation some time afterward with a retained placenta. This was removed under ether, the uterus irrigated and packed. The patient died during operation, and autopsy revealed no cause. A primipara, who had been subjected to great mental strain during pregnancy, had also suffered from grip with chronic bronchial catarrh; elimination had been badly performed. Fourteen hours after the first sign of labor, while the patient was in good condition, the fetus had descended to the pelvic floor and rotation was partially complete; the patient complained of suffering, and took 4½ ounces of Squibb's ether from a freshly opened can, administered by dropping upon gauze. The delivery of a large male child by forceps and the removal of the placenta, the patient had a respiratory spasm with persistent action of the heart.

Forty-five minutes after this respiratory failure was complete, and cardiac failure ten minutes later. An autopsy could not be obtained, but the symptoms were those of pulmonary embolism.

The third case was that of a neurotic woman who, some years previously, had a difficult labor with infection and lacerations. During a rest cure she was taken with thrombosis of the left lower extremity, with nephritis and pelvic peritonitis; thrombosis also extended to the right side. From this the patient recovered in two months and was then in good general condition. She requested operation to avoid the danger of repeated attacks.

On opening the abdomen some adhesions between the uterus and surrounding tissues were broken up; there were evidences of previous infection on the left side of the uterus; the ovaries were cystic, and the tubes showed evidence of chronic infection. The body of the uterus, tubes and ovaries were removed without hemorrhage or shock. The patient developed rapid pulse after the operation, but improved. Forty-eight hours after operation she died suddenly on awaking from sleep. On autopsy pulmonary embolism was present and caused death. In 18,800 women in childbirth, or after operation, 30 cases of immediate pulmonary embolism were reported, with a mortality of 73.33 per cent. Pulmonary embolism may also be secondary to a primary thrombosis; this is not unusual and is frequently preceded by a progressively rapid pulse, while the temperature of the patient may fall to normal. This rapid pulse, known as Mahler's Sign, was present in 63.33 per cent. of cases. Regarding the causation of immediate pulmonary embolism, no satisfactory explanation can be given which can be traced to any one manipulation, nor to any stage of labor. Those patients who have had pulmonary infections during pregnancy, or who have had disease of the blood vessels before labor, or operation, are most liable to its development. The most severe cases of labor frequently escape death in this form. So far as the treatment of pulmonary embolism goes, it consists in putting the patient at absolute rest and giving stimulants promptly. Where thrombosis precedes, much can be done to avoid accident by keeping the patient perfectly quiet. The author, from cases reported in 193 papers, aggregating 125 cases, compiled a table of 25 typical cases which is appended to the paper.

INHERITANCE OF TUBERCULOSIS.—Bossi's (*Archiv. of Gynakologie*) article is a contribution from an obstetrician to our knowledge of tuberculosis. He examined large numbers of placentæ and of fetuses from women with tuberculosis, supplementing his research by experimental work. He found that it was a very rare exception when the Koch bacillus was transmitted to the fetus from the parent during its intrauterine existence. The toxins of tuberculosis may be transmitted. They seem to accumulate in the placenta, and to pass thence into the fetus. The toxins thus transmitted are responsible for the defective development and organic weakness noted in such children. They favor infection during early infancy.—*Jour. Am. Med. Ass'n.*

Department of General Medicine.

In Charge of DR. E. M. DUPAQUIER, New Orleans.

COLLECTION OF URINE FOR EXAMINATION.—The urine of infants and young children is often quite difficult to collect. The following methods I have found very useful for collecting the urine for examination. In female infants a wad of absorbent cotton is placed over the vulva and held in place by the diaper, and examined from time to time. When it is found moist from the absorption of urine, it should be squeezed out over a vessel and the urine thus collected. A large cup placed close up against the vulva and held in place by the diaper is sometimes of advantage in collecting urine from female infants.

The catheter No. 10 F. is a sure way of collecting urine and often its use will have to be resorted to when other methods fail.

In male infants the absorbent cotton method is also useful. Still better is the application of a condom or rubber finger-cot placed over the penis (or penis and scrotum) and tied with a small tape around the waist. The child should be watched from time to time to see if he has voided any urine.

If an infant or young child of either sex is placed on a chamber occasionally and at the same time a cold hand or hot application be placed over the lower abdomen, urine will usually be soon forthcoming.

If the urine for examination has of necessity to be kept for some time before the examination can take place, it should be preserved in a corked bottle in a cool place.

For details of methods, etc., of the examination of urine, both chemical and microscopical, the reader is referred to any good book dealing with the subject of urine analysis. (The Physical Examination of Infants and Young Children by Theron Wendell Kilmer, M. D., 1906.)

INTERNAL USE OF CARBOLIC ACID.—It gives most excellent results, and this is not sufficiently widely known. It use by the author in rheumatic conditions (mono and polyarthritís) antedated the use of salicylic acid. Cardiac complications are favorably influenced. No untoward effects as with salicylates. Chorea minor and professional neuroses are amenable to the same treatment. So are affections of the tendons, aponeuroses, periosteum, and even bone. The method of administration is by needle; the solution is a 2 per cent. Carbolic acid acts as a powerful local antiphlogistic and absorptive agent. Because of these properties it has a valuable anodyne effect. It is an antitoxin, as proved by the influence exerted upon chorea minor, articular rheumatism and syphilis.

(Moritz Benedikt, M. D., of Vienna. Clin. Lect. Polyclinic, University of Vienna. Internat. Clin. Vol. 4. Fifteenth series, 1906.)

ORTHOSTATIC ALBUMINURIA, according to Le Noir's paper, had disappeared during the course of certain morbid or physiological states, namely, scarlatina, typhoid fever, pregnancy, and reappeared after the termination of the diseased conditions or after delivery, with all its characteristic features, the albuminuria and general condition remaining unaggravated. In these cases he found that albuminuria is bettered by a tonic régime, fortifying the organism. The prognosis of the morbid and physiologic states mentioned as having this peculiar reciprocal relationship with orthostatic albuminuria is not aggravated. (*Soc. des Hopitaux,* Feb. 9, 1906, *Progrès Medical.*)

THE DESMOID REACTION OF SAHLI.—Felix Eichler (*Berliner Klinische Wochenschrift,* No. 48, 1905) draws important conclusions from a series of thirty cases from Ewald's clinic as to the practical value of the new Desmoid Reaction of Sahli in the diagnosis of abnormal conditions of the stomach secretions.

This reaction, as first announced by Sahli during the past year, is founded upon the now thoroughly proved fact that the desmoid or connective tissue of our food is digested solely in the stomach, and only then in the presence of a sufficient quantity each of hydrochloric acid and pepsin.

Sahli uses this fact as a working basis of his method in the following clever manner: A small quantity of powdered methylene blue (about 2 gr.) is encased in a thin rubber membrane, which is puckered and tied tightly at one end with ordinary raw catgut, No. 00, care being taken that all possible egress of the methylene blue is prevented.

This bolus, very much of the shape and consistency of an ordinary pill, is given to the patient immediately following a regular mid-day meal, the constituents of which are entirely indifferent for the test.

If, now, the gastric juice contains approximately normal amounts of HCl and pepsin, the catgut, a desmoid tissue, is digested in the stomach, which results in a freeing of the methylene blue from its small rubber envelope. The powder is absorbed and appears in the urine, with its characteristic color reaction, within a certain definite period. If, on the other hand, the HCl or pepsin be absent or even diminished, the rubber bolus passes through the canal entirely intact, so that the urine remains free from the expected coloration. If the kidneys, from any cause, be suspected of a functional insufficiency, which might possibly interfere with the time limit of the test, potassium iodide can be substituted for the methylene and tested for in the saliva, the principle remaining the same.

The method is suggested and highly recommended by the author as a substitute for the test breakfast, not only because of its simplicity, but also in cases where for any reason the stomach tube is contraindicated or refused by the patient.

Eichler, after a careful and thorough testing of the method *in toto,* draws the following conclusions as to its value:

1. The plan is a simple and harmless one and commends itself especially to the busy practitioner who would gladly find a satisfactory substitute for the rather cumbersome stomach tubes.

2. The test being made immediately following a regular and full meal, is more likely to give a truer insight into the real status of the stomach secretions than does the artificial test breakfast.

3. A positive reaction within 15 to 20 hours is positive proof that the stomach is secreting approximately normal amounts of HCl and pepsin.

4. A negative reaction, or one in which the urine findings are delayed over 20 hours, would make us conclude that the gastric juice is lacking in either one of its digestive constituents—which one, however, the test fails to prove.

5. No definite conclusion as to a subsequent excess of HCl (a hyperchloridia or a hypersecretion) or the degree of diminution of the acid (a hypochloridia) can be drawn from the test.

6. In cases of hypermotility, in which the stomach empties itself too rapidly to allow of complete digestion of the catgut, a negative reaction might be decidedly misleading.

7. In conclusion, Eichler welcomes the reaction as a valuable addition to our methods of stomach examination, but with limits well defined and drawn. It lacks in exactness and precision and, in this sense, can by no means be considered as a substitute for the stomach tube and test breakfast.

THE TALMA OPERATION, WITH A REPORT OF A SUCCESSFUL RESULT.—W. J. de Wheeler (*British Medical Journal,* No. 23,336) reports a case of liver cirrhosis with marked and persistent ascites completely relieved by this operation.

The case was that of a 47-year-old locksmith, without alcoholic antecedents or history, who dated his entire sickness back but two months previous.

The abdomen, however, was already considerably distended, showing a circumference of about 65 inches, but outside of this the patient presented no other marked symptoms of the disease. A paracentesis yielded 2½ gallons of a yellow viscid fluid which now permitted the palpation of the hardened edge of the liver two fingers' breadth below the costal margin. After 14 days, owing to an enormously rapid refilling, the abdomen had to be again tapped, and, because of this rapid reaccumulation of the fluid along with a developing icterus and a suggestion of cachexia, the indication for the operation was thought to be fulfilled.

The technic followed the well-known lines, the whole operation lasting but three-quarters of an hour.

Convalescence was rapid and in seventeen days the patient was able to leave the hospital. He returned in four weeks and was relieved of about a quart of fluid, which had collected immediately following the operation from lack of proper drainage. Complete recovery, *i. e.,* as regards the ascites and other symptoms, followed, so that in half a year the patient had gained 18 pounds in weight.

Wheeler presents the following ideal indications for the operation: 1. Ascites without marked liver atrophy. 2. More especially the primary stage of hypertrophy with ascites. 3. The ascites must be of comparatively short standing.

The operation should not be performed: 1. In markedly atrophic livers. 2. When icterus is outspoken. 3. In the presence of kidney or heart lesions. 4. Ascites from all other causes will not be relieved by the operation.

Department of Ear, Nose and Throat.

In Charge of A. W. deRoaldes, M. D., and Gordon King, M. D., New Orleans.

RELATION BETWEEN THE CIRCULATORY APPARATUS AND AFFECTIONS OF THE EAR.—Stein, of Vienna, records the result of his observation in a hundred cases of deafness, tinnitus aurium, and other subjective phenomena of the ears, and found in forty-seven of them some abnormality of the circulatory apparatus, such as mitral obstruction, myocarditis, etc. The author concludes that the majority of such cases of ear troubles are dependent upon anemia. Interference with the venuous circulation produces more permanent changes in the ear than does hyperæmia, and is responsible for many cases of otosclerosis and labyrinthine disturbances. In such cases the local treatment should be secondary to those measures directed toward the relief of the circulatory defect. Alcohol and tobacco should be prohibited. (*Zeitschrift fur Obrenheilkinide,* September, 1905.)

Official Investigation by the Government in Holland of the Frequency of Adenoid Vegetation Among the School Children.—H. Burger, of Amsterdam, publishes the result of a most interesting research recently made by the Dutch government along these lines. Among 800,000 children it was found that 6 per cent. showed some external evidences of the presence of adenoids. Local examination by means of finger and anterior and posterior rhinoscopy of 13,283 children showed that 30 per cent. had abnormal enlargement of this gland. The author lays stress upon the frequence of external signs of adenoids and the importance of recognizing and removing the enlarged gland. This official investigation has done much to call deserved attention on the part of teachers and parents to the importance of the subject and the necessity of correcting the abnormal condition.

Miscellaneous.

Here is a letter humorously deriding the phraseology *a la mode* among physicians.

"My Dear Confrère:

"Simply in a few words, this is the opinion I have formed about the patient you have had the kindness to refer to me.

"There is here, I think, a somewhat special morbid process undergoing evolution, the genesis of which I fail to catch. We can hardly explain it unless we ascribe it to the hereditary deuteropathic bradytrophic dyscrasia and to a complex individual metabolism of the physiologic reactions ordinarily seen in circum-cellular plasmas.

"The antecedents reveal, most clearly, a sort of tuberculo-arthritic hybriditis of the interior connective tissue. Therein lies, in my humble opinion, the primum movens of that complexus of cryptogenic lesions.

"Our patient presented an alarming habitus, a pale facies and a full symptomatic cohort of diathesic visceral steatoses. I have tracked up a generalized micropolyadenopathy with pronounced phagedenic lesions, evidences of a deplorable nutritive circulus and of an idiosyncrasis which commands a reserved prognosis.

"I hold my diagnosis in suspense and think that armed expectation united with palliative measures will suffice until we are able to show why this affection should be placed in any particular category of our present nosological catalogue. Believe me,

"Yours, X.

—*Jour. de Med. Int.* Feb. 1, 1906.

Parisian Medical Gossip.

(Translated by DR. T. C. MINOR, Cincinnati, Ohio.)

THE MEDICAL PHILOSOPHY OF OCTAVE BILIARD.—Dr. Octave Biliard, in a medical feuilleton entitled *"Professional Philosophy,"* indulges in somewhat pessimistic views of the healing art. "Medicine is the modern priest-clergyman to a doubtful, badly formulated religion, that, contrary to others, permits no idleness in the minds of its servants, since they must sleep on deaf ears to immutable dogmas that must ever be sought after. The student must eternally seek for unknown species and varieties of pathological flora, *ever in defiance of the truth* of today that will, most probably, be the error of tomorrow. The physician is the victim of science, his versatile goddess. The modern medical schools, let us say seminaries, fill active professional life with mere conjectural knowledge and the elements of a laborous therapeutics, the insufficiency of which is often demonstrated by the very ones who most often serve as teachers. Modern college professors are wont to use the quasi-evangelical words "go and seek to cure all the nations of the earth in the name of Charcot, Bonchard and Brissaud." So the disciples of medicine go out into the world (like the priest). The doctor, too, is solitary—his silence, his cloister. It is easy for a man of letters to make the profane comprehend; if one speaks of the code with good sense, he will have passed the law school of medicine. It is true that a good stonecutter is not always an architect, and that it does not require a fine chemist to be a talented photographer; the physician has merely to question his patients to discover much that is *hidden from the rest of the world.* Yet to the vulgar mass the true doctor does not betray his book of knowledge; *he remains a mysterious personage to most of his clients.* The truth is, and every honest doctor will admit the fact, that most so-called physicians are blind men in a country full of blind people. The only thing he carries, as a rule, to guide him is the medical light of a glowworm size and inspiration enough for quick guesswork. It might seem an easy profession to live by, but, alas! the priest must live by his altar—and must make his congregation see clearly in order to be respected. *Sick people do not wish scientific doubt*—it is faith that they demand. The doctor who cannot have the confidence, *the faith, of his patients,* will never have a practice. Tortured by doubt, a medical priest *must lie,* because his lie is all too often a comfort to humanity. A lie that brings back hope—and often, too, health—is a lie well told. The medical end justifies the means employed, besides the business interests of a doctor must frequently justify the white lie. A doctor who hesitates to express a positive opinion to his patient, the physician who reveals the slightest expression of doubt in his face, is often mistrusted. The positive, special expert (?) diagnostician usually closes his jaws firmly and announces his diagnosis like the priest says his *credo* if he wishes to make his after prescription have the authority of a bull. All this costs an honest soul an immense amount of self-respect and after-remorse of conscience at the professional start. Once started on the road of medical lying, seeing the happiness wrought among the sufferers of humanity by rousing the seeds of illusion, a really conscientious doctor learns that there are more people cured on hope sustained often than were made by new remedies. If a physician is too honest to lie to his clients, they will leave the truthful doctor and seek for happiness in the one who can cheer them up by lively prevarication, and one, too, who often has performed medical miracles by lying. "Thou shalt not lie," said the old Mosaic law, but in the time of Moses the masses were much given to the faith cure.

So stands the modern medical priest in the temple of Aesculapius. The pride we take in ourselves as seekers after truth does not count with the vulgar crowd that only wishes the promise of a cure, such as the mystery-loving Behring promises to give the world for consumption—about 1908—or, perhaps, never.

There be, perhaps, interpolations in the text, but they are forced in by the natural drift of human thought. Our remote ancestors had a respect, even a fervor, for the magi—those wise men of the East. Sure it is that modern medicine never performs the miracles that ancient history universally and without doubt granted to the magi, but modern medicine daily makes claims to new specifics and infallible cures—cures all too often endorsed by men of some standing even in our higher medical schools. Yet modern medicine *must claim to perform* scientific miracles or our medical altars will be overthrown and our creed discouraged. Yes, it must be the modern medical miracle or the people would soon sit on the ruins of our college clinics, where modern medical lying is so largely practiced. For all which sentiments one's soul does not rest content, for, in the end, the lie never gained anything but a temporary advantage. That so many people now seek every new medical fad is only the natural result of a long period spent in lying about the illogical deductions drawn from the laboratory. With which digression we will close our further discourse.

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,, Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

ARRANGEMENTS FOR 1906 MEETING, MAY 8, 9, 10.

The Committee on Arrangements for the 1906 meeting met at the rooms of the Orleans Parish Medical Society on March 7, Dr. M. J. Magruder, Chairman, presiding.

The Chairman announced the following personnel of the Committee:

On Exhibits, Dr. Isaac Ivan Lemann, 124 Baronne.

On Registration, Dr. J. B. Elliott, Jr., 107 Camp.

On Banquet, Dr. Gordon King, 624 Gravier.

On Program Advertisements, Dr. John Smyth, 624 Gravier.

All the committees are hard at work and everything points to a large attendance and an interesting and enthusiastic meeting.

ONE FARE FOR THE ROUND TRIP.—Owing to the importance of the meeting this year, the railroads are making liberal concessions and most of them have already agreed to make a rate of one fare for the round trip, plus twenty-five cents. There are only a few roads to hear from and these will no doubt make the same concession.

No receipts or certificates will be required. This is a very low rate and will, we hope, encourage a large attendance; it will not be restricted to members, but those desiring to do so may procure tickets for relatives and friends at the same rate.

These tickets can be had only on the 7th and 8th of May, and will be good to return until the 12th.

For any further information concerning these matters, address the Chairman of the Arrangement Committee.

DISTINGUISHED VISITORS.—The Committee on Arrangements is pleased to announce that Dr. James Carroll, who did such valuable work in the campaign against the mosquito in Havana, will be in attendance at the meeting and will read a paper.

Dr. W. S. Bickham, of New York, will also be a guest of the Society and will read a paper on "The Surgery of the Nervous System."

CHAIRMEN OF SECTIONS, SUBJECTS FOR DISCUSSION AND OPENERS OF DISCUSSION.

General Medicine.—Chairman, Dr. F. M. Thornhill, Arcadia.

Subject: Typhoid Fever.—To open discussion: Drs. H. P. Jones, New Orleans, and A. F. Barrow, St. Francisville.

Ophthalmology.—Chairman, Dr. H. D. Bruns, New Orleans.

Subject: What Every Physician Should Know of Ophthalmology.—To open discussion: Drs. F. E. Girard, Lafayette, and Oscar Dowling, Shreveport.

Surgery.—Chairman, Dr. J. D. Bloom, New Orleans.

Subject: Mechanical Treatment of Fracture of Patella.—To open discussion: Drs. J. T. Bringier, Burnside, and T. E. Schumpert, Shreveport.

Anatomy and Physiology.—Chairman, Dr. A. R. Trahan, Lafayette.

Subject: The Anatomy and Physiology of Adrenals.—To open discussion: Drs. Henry Bayon, New Orleans, and B. A. Colomb, Union.

Obstetrics and Gynecology.—Chairman, Dr. Randell Hunt, Shreveport.

Subject: (To be announced later.)—To open discussion: Drs. Paul Michinard, New Orleans, and T. L. Mills, Jr., Baton Rouge.

Original papers in this section:

"Some Advantages of the Vaginal Route in Pelvic Surgery," by Dr. C. Jeff. Miller, New Orleans.

"The Treatment of Reducible Retrodeviations of the Uterus," by Dr. L. Perrilliat, New Orleans.

Oral Surgery.—Chairman, Dr. Samuel Logan, New Orleans.

Subject: (To be announced later.)—To open discussion: Dr. Emile Regard, Mansura.

Sanitary Science and Quarantine.—Chairman, Dr. Fred J. Mayer, Scott.

Subject: Symposium on the Sanitary Control of Yellow Fever.—To open discussion: Drs. John Callan, New Orleans, and B. O. LeBlanc, St. Gabriel.

Original papers in this section:

"How the Yellow Fever Situation Was Handled in Kenner in 1905," by Dr. Stephen D. Gustine, Kenner.

"My Experience as to the Recognition of Early Primary Cases," by Dr. E. M. Dupaquier, New Orleans.

"My Experience as to the Education of the Laity," by Dr. E. M. Dupaquier, New Orleans.

"Personal Experience in the Country During the Occurrence of Yellow Fever in 1905," by Dr. C. Milo Brady, New Orleans.

Maritime and Inland Sanitation (Sub-section.)—Chairman, Dr. S. L. Théard, New Orleans.

Subject: Requirements of Maritime and Inland Sanitation in the Light of the Mosquito Doctrine.—To open discussion: Drs. J. N. Thomas, Quarantine, and G. Farrar Patton, New Orleans.

Materia Medica and Therapeutics.—Chairman, Dr. J. T. Halsey, New Orleans.

Subject: The Advantages of Physiologically Assayed Preparations.—To open discussion: Drs. Charles McVea, Baton Rouge, and S. K. Simon, New Orleans.

Medical Jurisprudence.—Chairman, Dr. Philip Asher, New Orleans.

Subject: (To be announced later.)—To open discussion: Drs. E. S. Matthews, Bunkie, and Allan Eustis, New Orleans.

X-Ray and Electro-Therapeutics.—Chairman, Dr. Amédée Granger, New Orleans.

Subject: The Importance of a Knowledge of Electro-Therapeutics to the General Practitioner of Today.—To open discussion: Drs. N. F. Thiberge and Gustave Keitz, New Orleans.

Diseases of Children.—Chairman, Dr. Louis Abramson, Shreveport.

Subject: Rheumatism in Children.—To open discussion: Drs. G. King Logan, New Orleans, and F. H. Carruth, Lobdell.

Original papers:

"The Diet and Handling of the New-born," by Dr. L. G. LeBeuf, New Orleans.

Dermatology.—Chairman, Dr. J. F. Buquoi, Convent.

Subject: Pruritus and Its Treatment—To open discussion: Drs. Isadore Dyer and J. N. Roussel, New Orleans.

Neurology.—Chairman, Dr. Clarence Pierson, Jackson.

Subject: Foreign Immigration, With Concomitancy, Considered from a Psycho-Neurological Standpoint.—To open discussion: Drs. L. L. Cazenavette, New Orleans, and W. E. Kittredge, Napoleonville.

Original papers:

"The Treatment of Tabes Dorsalis," by Dr. Roy M. Van Wart, New Orleans.

"The Cause of Insanity," by Dr. E. M. Hummel, Jackson.

Genito-Urinary Diseases.—Chairman, Dr. S. P. Delaup, New Orleans.

Subject: Surgical Treatment of Prostatic Hypertrophy.—To open discussion: Drs. C. Menville, Houma, and Jules Lazard, New Orleans.

Original papers:

"The Venereal Peril and Public Apathy," by Dr. A. Nelken, New Orleans.

Otology.—Chairman, Dr. Homer Dupuy, New Orleans.

Subject: Laryngeal Tuberculosis; Its Early Diagnosis, Treatment and Prevention.—To open discussion: Drs. C. J. Landfried, New Orleans, and J. A. Caruthers, Baton Rouge.

Bacteriology.—Chairman, Dr. John J. Archinard, New Orleans. —Subject: Bacteriology as an Aid, from a Diagnostic Standpoint. —To open discussion: Drs. O. L. Pothier and J. D. Weis, New Orleans.

Original Papers.—Members desiring to read original papers at the coming meeting are requested to send in their titles without delay, if they desire to be accorded a place on the program. The Committee on Scientific Work has decided to accept no title sent after April 16, as all copy for the program must be in the printers' hands at that date.

RESOLUTION OFFERED BY B. A. COLOMB, M. D., AT THE MEETING OF THE ST. JAMES PARISH MEDICAL SOCIETY.—The St. James Parish Medical Society endorses the movement against the patent medicine fraud in the United States as a crusade in the interest of the general public. We believe it is our duty to enlist in the work inaugurated by two lay journals, and now being taken up by the medical journals of this country.

(1) By informing, as much as in our power lies, the various people who look to us for medical supervision of their families, of the composition and harmfulness of the concoctions sold to them under various names.

(2) By not prescribing these patent concoctions for our patients. We further believe that the best and most quickly efficacious method of destroying this plague would be for the American Medical Association, through its component State and County Societies, to distribute literature to the people direct giving them reliable information as to the composition, effects, etc., of the principal patent medicines and leave them to draw their own conclusions concerning the others. These noxious compounds could not be sold except by the most extensive advertising of their fictitious curative properties, and this sale can be stopped only by the same extensive knowledge of the fact that they have no medical virtues at all, but are, in many instances, potent agents for great harm.

RESOLUTION OFFERED BY B. A. COLOMB, M. D., AT THE MEETING OF THE ST. JAMES PARISH MEDICAL SOCIETY.—We hereby protest against the practice of certain life insurance companies in paying less than five dollars ($5) for any medical examination. We see no reason why a smaller fee should be paid for one examination than for another, since the work is always the same. We cannot further understand why some life insurance companies have been able to maintain a minimum examination fee of five dollars ($5) while others have not. We have noted with surprise that, while the examination fees were being cut down on the plea of economy, all the other expenses were enormously increased, although the examining physician is the most important employe of any company, as its success or failure will depend upon the quality of his work.

We demand that the Louisiana State Medical Society take some action upon this question at its next meeting, and that it be brought before the American Medical Association in proper form.

Medical News Items.

THE LOUISIANA CHEMICAL SOCIETY.—The organization of the Louisiana Chemical Society, on February 17, in this city will prove of great benefit. The Louisiana Society will be a branch of the national association. The following officers were elected: Dr. William R. Betts, President; Dr. R. E. Blouin, Vice-President, and Dr. Flournoy C. Johnson, Secretary and Treasurer.

TESTIMONIAL TO THE EYE, EAR, NOSE AND THROAT HOSPITAL.—Mr. James T. Hayden has resigned the chairmanship of the finance committee of the Eye, Ear, Nose and Throat Hospital, accompanying his letter of resignation with a handsome testimonial to that institution, to whose welfare he has contributed so much. Mr. Hayden resigned because he expects to be absent from the city much of the time.

PURE FOOD BILL.—After fifteen years of more or less serious consideration of the subject, the Senate passed a pure food bill by a vote of 63 to 4.

SPURIOUS DRUGS.—David B. Comer and David B. Comer, Jr., and John E. King, indicted more than a year ago for using the mails for schemes to defraud, yesterday appeared before Judge Toulmin in the Circuit Court and withdrew their former pleas of not guilty. They asked to be allowed to plead guilty and the Court accepted the pleas and fined them $250. These cases attracted considerable attention because of the scheme operated by the Comers and King with the aid of the United States mails. They were the German Chemical Company and they sold to druggists all over the country a certain preparation of phenacetin represented to be the genuine coal tar product from Elberfeldt, Germany.

LEPROSY HOSPITAL IN THE HAWAIIAN ISLANDS.—Dr. Walter R. Brinckerhoff, of the Harvard Medical School, has received the appointment as director of the United States Government Leprosy Research Hospital which is to be established on Molokai, the island on which the lepers are now segregated. On his way to his post the doctor spent a few days in New Orleans and paid a visit to the Louisiana Leper Home.

HOT SPRINGS CITIZENS WIN FIGHT AGAINT MEDICAL "RUNNERS."—The Supreme Court of Arkansas has declared as valid the State law passed in 1904, prohibiting the drumming of patients for doctors. It is held that the Visitors' Protective Association, of Hot Springs, was engaged in a lawful undertaking in endeavoring to have this law enforced, and should not have been enjoined from so doing by the lower court.

NEW INFIRMARY AT BESSEMER, ALABAMA.—Dr. Tom Robinson has recently opened a small infirmary in Bessemer, Ala., and Mrs. Laura Reynolds Mullen, a graduate of the New Orleans Training School, has been placed by him in charge of the little institution, which we hope will attain the success it deserves.

NOTABLE APPOINTMENT.—Dr. Amedée Granger, Secretary of the Orleans Parish Medical Society, has been appointed Secretary of the American Committee of the International Congress of Physiotherapy and elected a member of the Societé Francaise d'Electrothérapie, of Paris.

SXITEENTH INTERNATIONAL CONGRESS OF MEDICINE (Lisbon, April 19-26, 1906).—"The Executive Committee of the Sixteenth International Congress of Medicine have secured a considerable number of apartments (rooms with one bed, or, for the most part, with several beds) at a price of 6, 8 and 10 fr. a bed, according to the location. There are also some lodgings with board at 15 francs a person.

Tickets will be paid for at the gate of the Rocio (entrance to Lisbon when arriving by train) and for the length of the Congress, which will be eight days.

There are all facilities for repasts in the restaurants and hotels of Lisbon, as also in the restaurant of the Congress.

All lodgings will be distributed with the arrival of demands, the same to be addressed, before the 31st of March, to Mr. Manoel Jose da Silva, Palacio Foz, Praca dos Restauradores, Lisbon, who has charge of this service.

Definite arrangements have been made with the French, Spanish and Portuguese railroads which permit the congressionists to effect the voyage in returning by an itinerary very different from that which they took in coming, always at a reduction of 50 per cent., on condition that the going and coming are made worth their while. We understand also that the Italian railroads will give the same reduction."

ANNOUNCEMENT FROM NEW YORK SKIN AND CANCER HOSPITAL.—Dr. L. Duncan Bulkley will give four special lectures on the "Principles and Application of Local Treatment of Diseases of the Skin" on March 21 and 28, April 4 and 11. Dr. William Seaman Bainbridge will give a clinical lecture on "Malignant and Non-Malignant Growths" on April 18. These lectures will be free to the medical profession.

MEETING OF THE STATE NURSES' ASSOCIATION.—The State Nurses' Association at their last annual meeting, held in the parlors of the Dental College, elected the following officers: Miss Fromherz, President; Miss O. Norman, Secretary, and Miss Dent, Treasurer. Thirteen new members were elected. At the close of the meeting the Association was entertained at Miss Goodwin's, in Antonine street.

MEMORIAL TO DR. N. S. DAVIS.—Dr. Charles Chassaignac has been appointed the representative from Louisiana in regard to soliciting funds for a proper memorial to the late Dr. Davis, of

Chicago, the founder of the A. M. A. It is desired to secure small contributions from many and it is hoped that the sum of $250 or more can be raised by Louisiana.

All those desiring to subscribe are requested to communicate with the JOURNAL.

GONE TO CENTRAL AMERICA.—The following doctors who have been attending the New Orleans Polyclinic have gone to Central America as Medical Inspectors on fruit steamers for the State Board of Health: Drs. J. C. Davis, J. W. Phillips, V. H. Caine, A. C. Miller, O. Patton, G. W. Cross, R. H. Harrison, A. Aiken and T. P. Bell.

There are a number of doctors attending the New Orleans Polyclinic who are on their wedding trip. It has become quite fashionable for recently married couples to spend their honeymoon in New Orleans while the doctor does post graduate work at our Polyclinic.

PERSONALS.—Dr. R. O. Simmons of Alexandria, La., has been elected President of the Parish Board of Health, vice Dr. A. R. Choppin, resigned.

Dr. S. C. Barrow has moved from Torras, La., to Shreveport. The doctor has been doing some post graduate work recently.

Dr. S. G. Gill, who has heretofore been in charge of the lower quarantine station, has been sent by the State Board as resident medical inspector at the port of Havana.

Dr. W. J. Baird, of Plain Dealing, La., has been appointed Coroner of Bossier Parish.

Dr. F. R. Harrell, of Ruston, has moxed to Alexandria, La., and will limit his practice to the eye, ear, nose and throat.

Dr. Wallace J. Durel, medical director of the Louisiana Tuberculosis Sanitarium at Covington, La., has opened an office in the Morris Building, and will confine his practice to diseases of the lungs.

Dr. Raymond Wallace, the genial editor of *Southern Medicine and Surgery,* of Chattanooga, Tenn., was in the city and paid the JOURNAL a pleasant call.

At the last meeting of the Shreveport Medical Society Dr. T. E.

Schumpert tendered the members a most enjoyable luncheon at the close of the meeting.

Dr. E. M. Ellis has resigned from the presidency of the Crowley Board of Health and will move to Forth Smith, Ark., to practice.

Drs. J. F. Points and J. W. Groetsch, medical inspectors for the School Board, examined 1,252 children in three schools and in 513 children there were no evidences of vaccination.

Miss F. M. Quaife, superintendent for the past ten years at the Touro Infirmary, has resigned. The Board presented her with an appropriate memento in recognition of her services.

Dr. H. T. Lemoine has moved from Big Cane to Cotton Port, La.

Dr. R. H. Blackman has left Plain Dealing and located at Ruston.

Dr. W. Pool, of Corn Hill, Texas, who attended the New Orleans Polyclinic last year, has moved to Learned, Miss.

Dr. J. L. Wilson, from Alexandria, La., was in the city. He brought his daughter here for treatment, and while here did some post graduate work.

Dr. T. M. Taler, of Gillsburg, Miss., has moved to Crowley, La., and bought the home of Dr. E. M. Ellis.

Married.—The marriage of Dr. J. F. Points to Miss Amelia Josephine Simms was solemnized on the 7th of March.

On March 14 the wedding of Dr. Herman White to Miss Edna Aarons took place at the home of the bride.

Died.—Dr. Ira Eddins, at Laurel, Miss., on March 4. The doctor was a young man just entering on the practice of his profession.

The death of Dr. Albert Voorhies occurred on March 16 at El Paso, Texas, where the doctor had gone for his health.

Dr. W. A. Jones, prominent physician, planter, and member of the Morehouse Police Jury, died at Jones, La., on March 16, after a short illness.

Dr. Thomas Farrar Richardson died at the New Orleans Sanitarium on Monday, March 19. The doctor was a surgeon in the United States Public Health and Marine Hospital Service and was Dr. White's aide during the yellow fever campaign last summer. Dr. Richardson was a native of New Orleans and had attained marked distinction in his profession at the time of his demise.

Dr. Sebastian Hiriart, who died in New Orleans at the Sanitarium on March 18, was a prominent citizen of Plaquemine, where his remains were taken for burial.

Dr. J. C. Legrande, editor of the *Alabama Medical and Surgical Journal,* and a member of the faculty at the Birmingham Medical College, died March 21 at his home in Birmingham. He leaves two daughters and two sons.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Physical Diagnosis, by EGBERT LEFEVRE, M. D. Lea Brothers & Co., Philadelphia and New York, 1905.

This is the second edition, thoroughly revised and enlarged, of an excellent manual for students and physicians. It includes the diseases of the thoracic and abdominal organs and is beautifully illustrated with 102 engravings and sixteen plates. Especial emphasis is laid on the altered anatomy of the organs under examination, and its relation to the physical signs. The respiratory and cardiac sounds, their production and modifications, both normal and pathological, have been discussed more fully than in most books of moderate scope. E. M. D.

Lectures on Auto-Intoxication, by PROF. BOUCHARD, of Paris, France, translated by THOMAS OLIVER, London. F. A. Davis Company, Philadelphia, 1906.

This is a second revised edition of the masterly lectures of Bouchard. New matter has been interposed in the text by the editor, who has presented an appendix, where he considers the natural defenses of the organism against disease and internal secretions. E. M. D.

Man and His Poisons, by ALBERT ABRAMS, A. M., M. D. Treat & Company, New York, 1906.

This is a practical exposition of the causes, symptoms and treatment of self-poisoning, presented in the characteristic style of the well-known author of the Blues. As he well says, the subject of self-poisoning has advanced from a plausible and fascinating theory to a verity. An appendix is attached with original notes, of which Note 9, on Fletcherism, is worth reading, indeed. E. M. D.

Clinical Methods, by Robert Hutchinson, M. D., F. R. C. P., and Harry Rainy, M. A., F. R. C. P., Ed., F. R. S. E. Ninth edition. W. T. Keener & Company, Chicago 1905.

This is a complete guide to the practical study of medicine with upwards of 150 illustrations and nine colored plates, containing all the new material likely to prove of permanent value and capable of clinical application. E. M. D.

Disorders of Metabolism and Nutrition, by Prof. Dr. Carl Von Noorden, translated by Florence Buchanon, D. Sc., and I. Walker Hall, M. D. Treat & Company, New York, 1905.

This is part VII on Diabetes Mellitus, its pathological chemistry and treatment, of the clinical treatises dealing with pathology and therapy of Disorders of Metabolism and Nutrition by the well-known physician-in-chief in the City Hospital, Frankfort a. M. This last monograph of the remarkable series already published contains the lectures delivered in this country by the author himself. The perusal of these lectures will prove a boon to both the sufferer and the practitioner, as it will convince the reader that the old-fashioned routine treatment of diabetes is absurd.

E. M. D.

International Clinics, a quarterly of illustrated clinical lectures and original articles, edited by A. O. J. Kelly, A. M., M. D. J. B. Lippincott Company. Philadelphia and London, 1905.

This is volume III, fifteenth series, 1905, containing excellent articles on the therapeutic uses of the Roentgen rays, or radiotherapy; the action of metallic ferments on metabolism, and their effects in pneumonia; the musculo-tonic and diuretic action of formic acid and the formates; the symptomatic treatment of tuberculosis; the treatment of renal insufficiency; serumtherapy; mucous colic or membranous colitis; injuries and lesions following the toxic use of alcohol; ulcer of the stomach, with contractions, in a boy aged fourteen years; cerebral hemorrhage and lumbar puncture; curable albuminuria; Addison's disease; a case of chronic jaundice and great enlargement of the liver, due to primary carcinoma of the extra-hepatic bile duct, commencing at the junction of the hepatic ducts; fractures of the patella; paraffin injections by the "cold" process; ethyl chlorid its value as a general anesthetic; the differential diagnosis of tumors of the right hypochondrium; acute anterior poliomyelitis, paralysis agitans; syphilitic necrosis of the frontal bone; hay fever and asthma; carbonic acid gas applications in rhinitis; major trauma of the eye in general practice; gonorrhea and conjunctivitis; cirrhosis of the liver.

E. M. D.

Publications Received.

D. Appleton & Co., New York and London, 1906.
Modern Clinical Medicine, Cabot-Salinger.

Transactions of the American Surgical Association. (Vol. 23.)
Transactions of the Medical Association of the State of Alabama, 1905.
Anemia in Porto Rico (*Preliminary Report,* 1905), January, 1906.
Bulletin No. 1 of the Laboratory of the Board of Health Isthmian Canal Commission, by Arthur I. Kendall, Ph. D.
Report of the Department of Public Health of the Isthmian Canal Commission for the Month of December, 1905, by Col. W. C. Gorgas.

Reprints.

An Analysis of One Hundred and Fifty-two Cases of Hallus Valgus in Seventy-seven Patients, etc. (2) *Outdoor Life Versus Confinement in the Treatment of Bone Tuberculosis,* by Dr. H. Augustus Wilson.

Surdite, Vertiges et Bourdonnements, by Dr. Marcel Natier.

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR FEBRUARY, 1906.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	3	1	4
Intermittent Fever (Malarial Cachexia)	1	....	1
Smallpox	....	....	....
Measles	....	....	....
Scarlet Fever	....	....	....
Whooping Cough	1	....	1
Diphtheria and Croup	4	....	4
Influenza	14	2	16
Cholera Nostras	....	....	....
Pyemia and Septicemia	1	....	1
Tuberculosis	41	36	77
Cancer	10	6	16
Rheumatism and Gout	5	....	5
Diabetes	2	....	2
Alcoholism	3	1	4
Encephalitis and Meningitis	4	1	5
Locomotor Ataxia	1	....	1
Congestion, Hemorrhage and Softening of Brain	21	12	33
Paralysis	1	....	1
Convulsions of Infants	1	....	1
Other Diseases of Infancy	13	10	23
Tetanus	2	6	8
Other Nervous Diseases	1	....	1
Heart Diseases	48	36	84
Bronchitis	3	2	5
Pneumonia and Broncho-Pneumonia	35	38	73
Other Respiratory Diseases	11	3	14
Ulcer of Stomach	1	1	2
Other Diseases of the Stomach	1	1	2
Diarrhea, Dysentery and Enteritis	13	7	20
Hernia, Intestinal Obstruction	2	....	2
Cirrhosis of Liver	5	2	7
Other Diseases of the Liver	2	....	2
Simple Peritonitis	....	1	1
Appendicitis	....	1	1
Bright's Disease	29	18	47
Other Genito-Urinary Diseases	3	2	5
Puerperal Diseases	1	3	4
Senile Debility	21	6	27
Suicide	2	....	2
Injuries	18	18	36
All Other Causes	12	9	21
TOTAL	336	223	559

Still-born Children—White, 19; colored, 16; total, 35.

Population of City (estimated)—White, 245,000; colored, 88,000; total, 333,000.

Death Rate per 1000 per annum for Month—White, 16.45; colored, 30.41; total, 20.14.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	**30.19**
Mean temperature	**52.**
Total precipitation	**2.25 inches.**

Prevailing direction of wind, north.

New Orleans Medical and Surgical Journal.

VOL. LVIII. MAY, 1906. No. 11

Original Article.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints, may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

Third Stage of Labor.*

By DR. E. STANLEY MATTHEWS, Bunkie, La.

The third, or placental, period of labor lasts from the birth of the fetus to the extrusion of the placenta.

There is perhaps no time in the exercise of professional duties when we feel greater concern for those entrusted to our care than during this usually brief stage of midwifery. It is a stage about which we have to conjecture until it is passed, and when completed, the uterus empty and contracted, we feel as though the Sword of Damocles had been raised from above us.

The complications met, unexpected as a rule, are usually grave and demand professional skill, celerity of action, and a preparedness made in advance that will facilitate in the management. Woe to the physician who experiences one aggravated and perhaps fatal case of post-partal hemorrhage, when perhaps it could have been averted or arrested by anticipating and making ready. Some texts recommend that physicians attending the practice of midwifery be legally required to carry certain articles and drugs necessary to meet the most common exigencies likely to arise. This, I feel sure, is a thrust in the right direction, but it seems unnecessary legislation and irrelevant where medicine is practiced reputably.

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* Read before Avoyelles Ph. Medical Society.

In this brief paper I shall not attempt to enter into a lengthy description of the stage, nor into a discussion of some of the commoner complications met. I will, therefore, select from the stage a few of the phenomena observed, and I hope in the discussion which will follow you will outline the usual practicable methods you employ for the safe delivery of the mother from the stage.

I recall, when a second course student at college several years ago, I intended spending the vacation on a sugar farm about ten miles from the nearest physician. I had never seen a case of midwifery, and I feared I might be called on in this doctorless neighborhood to attend some case. In anticipation of such emergency, I applied before leaving the city to the surgeon in charge of a large hospital to permit me to attend one case with the interne in the maternity ward. His answer when he had heard my case stated was: "No. If they send for you, go; the woman will deliver herself." Well, this might be the case in hospital practice, but five years of professional experience has taught me differently.

The placenta with which we have to deal is normally attached to the anterior or posterior surface of the uterus; rarely is it attached to the fundus, and only in cases of placenta previa is the attachment near the internal os. In this position it remains attached to the uterine wall until the third stage, when by uterine contractions it is detached and, together with the membranes, amnionic fluid and resultant hemorrhage, it is expelled into the cavity of the uterus, then from that cavity to the vagina, and then through the vulvar orifice. This is followed by a firm contraction of the muscular fibres of the uterus. In the majority of cases this classical set of phenomena is observed, much to the satisfaction of the attendant; but a minority pursue an adverse course, and it is with these I will tarry awhile.

What practicable means do we employ to whip up a jaded, worn-out patient and uterus to tide us over the crisis into a haven of safety, when all apparent strength and endurance have been spent in a completion of the second stage? To leave such a patient to pursue the classically described course above outlined is flirting with disaster, and some manual means seems to suggest itself. This is the most delicate and precarious situation in which we can be placed. Some first course student would say, "Give a hypodermic of ergot." This would cause a tetanic contraction of the uterus, with placenta and membranes locked inside; maybe cause a large subcutaneous abscess or tissue slough in the site the hypodermic was given. This latter happened once in my practice, though I was never guilty of giving ergot until the third stage had terminated.

Perhaps at this crucial moment, if your assistant was an unregistered, unprosecuted midwife of Avoyelles Parish, and noticed your perplexity, she would advise you to pull on the cord. This would be equally calamitous. It tends to pull the placenta flatwise (like a button in a buttonhole), thus obstructing its egress, and if the placenta were still adherent invert the womb.

A practice sometimes followed by practitioners in these cases of inertia uteri, or apparent inertia, when the placenta is not delivered within the first twenty minutes following the second stage, is to wash the hands, lubricate the right hand and forearm, place the left hand over the fundus uteri, and with the cord as a guide follow it into the uterus and manually detach, or remove it if already detached. This practice has the highest condemnation of the best authorities. Stumpf, a German authority, in the American Text Book of Obstetrics, epitomizes the act as "the most dangerous obstetrical operation." Williams, Professor of Obstetrics at Johns Hopkins, says, in his latest work, "The procedure is more serious than the performance of version or the application of forceps."

If you pause a moment and reflect on conditions, you will at once appreciate the warnings of these eminent men. The hand is rarely sterile—it is introduced into the uterine cavity, carrying with it bacteria of many varieties, and there comes in direct contact with a freshly wounded placental site, through which are scattered numerous bleeding or thrombosed vessels, which afford them an excellent culture medium.

Manual removal of the placenta should only be undertaken when the condition of the patient is serious or there be free hemorrhage. As long as there is no hemorrhage, concealed or visible, interpreted by the palpating hand over the abdomen, do not introduce your hand, but continue the method of Crede, so well known to you. Use it during pains, or in their absence imitate them at intervals for at least two hours. This seems a long, tedious wait, but when you have the satisfaction of conviction of having followed the teachings of the best obstetrical authorities of the world, and saved your patient a possible inoculation and death from puerperal infection, you may well go home and

"Sleep the sleep that knows no breaking,
Morn of toil, nor night of waking."

Society Proceedings.

Orleans Parish Medical Society.

President, Dr. C. Jeff. Miller. *Secretary,* Dr. Amedee Granger
141 Elk Place, New Orleans.

In Charge of the Publication Committee, Dr. Amedee Granger, Chairman
Drs. Geo. S. Bel and E. H. Walet.

Meeting of March 10, 1906.

Dr. C. W. Allen read a paper entitled

Impotency In The Male.

There are few conditions not productive of bodily pain that cause as much mental suffering and distress as impotence, and few patients more grateful than those who are relieved of this condition. Virility is a mark of vigorous manhood, and if we are to fully appreciate its influence on the individual we can study it best in those who have lost this function. Most of these patients are usually very miserable, frequently given to brooding and become melancholy. Their stories are long and pitiful; many of them think their cases unique, blame themselves for past excesses and abuses, and eagerly employ all manner of remedies and treatment to conjure back their lost forces; offering a rich harvest to the quack, whose ever-conspicuous and alluring advertisement draws them in. The actions and manner of the impotent frequently lack that confidence which insures success in much that we do. Personal courage is not so marked and they are easily discouraged in their undertakings. Ambition is closely allied to sexual power; without it, the spark of ambition is likely to die and rarely develops before puberty.

"Old and young men essentially differ mentally on account of the condition of their virility. Impotence has a detrimental effect upon the feeling of well-being, mental freshness, activity and self-confidence. The sudden loss of virility may lead to severe melancholia and even to suicide,"[1] and we witness with horror the direful results which sometimes accompany castration in the virile subject.

The impotent father is very likely to be neglectful of his children begotten in his more virile days, is capable of less devotion, both to wife and children, is frequently irritable, cross, moody and apt to be cruel.

"Sexual passion is the basis of nearly all love between man and wife or man and mistress. The spiritual side of love, if bereft of the virile sexual impulse, would form weak ties. With all the morality which love needs to rise to its true and pure character, its most vigorous root is nevertheless sexual passion.

"Platonic love is a nonentity, a self-deception, a wrong designation for cognate feelings."[2]

CAUSES—Among causes we can first consider those structural malformations and defects of the sexual organs, congenital or acquired, which prevent the sexual act, such as absence of the penis, its excessive size or smallness, vicious directions from calcified plates in its fibrous sheath or gumma of corpora cavernosa, tumors, absence or loss of testes, or disease which may destroy them, as gumma or tuberculosis, and cryptorchidism; a cryptorchid, however, may be potent, but is nearly always sterile.

After the loss of the testes desire and ability may persist for a while, but the discharge in these cases is the secretion from the prostate and other glands, which, however, soon ceases.

Among the functional causes onanism unquestionably takes first place. Its excess causes immoderate pollutions and consequent spermatorrhea, which are the frequent direct causes of impotence.

I have a case of onanism under treatment at present who is excited to seminal losses by the mere contact of a woman, as in dancing, when an escape will occur, but it is always preceded or only occurs when he has had some thought producing excitement. These losses are without sensation.

Authorities differ as to the relative frequency of other causes, as the after-effects or sequelæ of gonorrhea, as posterior urethritis, prostatitis, seminal vesiculitis. Sexual excesses and perverted sexual instincts add their quota.

Constitutional conditions or diseases may impair or destroy virility, emaciation, obesity, anemia, nephritis, endocarditis, diabetes, injuries and diseases of the nervous system, such as meningitis, myelitis, progressive muscular atrophy and tabes dorsalis, except in the first stage, when desire and ability are increased.

After serious illness, as diphtheria or typhoid, the sexual function may be slow in returning or its loss may rarely be permanent.

A severe cold may temporarily affect potency; the sense of smell frequently influences the sexual appetite; as noted in the lower animals during their mating season, the olfactory nerves and odoriferous sexual glands are most active, and recent investigations have shown that during the sexual orgasm an intense nasal congestion occurs, sometimes sufficient to occlude the nares, forcing the animal to breathe through the mouth; thus showing some connection between this membrane, or its nerves, and the sexual organs.

The indulgence in all kinds of sexual excesses frequently leads to different grades of paralytic impotence. Complete paralysis of the sexual centres and nerves occurs, however, very seldom, as long as the individual can keep vigorous and healthy; but any of the numerous forms of sexual neurasthenia may eventually pass into paralytic impotence.

The habitual use of opium, morphin and hashish, while at first increasing sexual desire markedly, probably through congestion and irritation of the spinal cord, eventually retard it, and finally may produce atrophy of the genitals.

Lead poisoning, acute or chronic, chronic arsenic poisoning and the habitual use of chloral may result in impotency. The long use of mercury and the iodides, particularly the iodides, may produce impotency, and are accredited with causing atrophy of the testicles.

The excessive use of alcoholics and tobacco may be mentioned here; malt liquors especially dull the sexual instinct.

Diseases causing local irritation frequently increase sexual desire for a time by causing a hyperemia of the parts; among these conditions may be mentioned inflammation of the neck of the bladder, cystitis, urinary calculi, vesical ulcers, sometimes chronic anterior and posterior urethritis, particularly when the colliculus seminalis is involved. When increased desire is caused by this condition, a reaction is sure to set in, when the pendulum will swing the other way, and then will follow diminished or absent desire in proportion as the previous irritation was of long duration, intense or mild.

It is a constant observation to experience difficulty in controlling the sexual hygiene of patients suffering from these irritative lesions.

"Inflammation of the prostatic urethra bears the same relation to the spinal reflexes of the male that inflammation of the uterus bears to allied disorders in the female, and that it is a constant source of irritation of the genital nerves which terminate in that locality.

"An enfeebled state of the lumbar division of the cord and exhaustion of the cells that minister to its reflex functions are thus finally brought about."[3]

Another cause of hyperemia of the posterior urethra is constant excitement of the genital organs without gratification, brought about by lascivious thoughts, pictures or literature, or the pernicious habit of toying with females.

"The vesiculæ seminalis, the prostate and other neighboring glands, are sometimes filled with the products of their secretion. The result is hyperemia and its consequences. Whenever a physician thinks milking of the seminal vesicle or massage of the prostate were indicated, he can safely order regular, and, if possible, repeated sexual intercourse. There are many cases treated and maltreated with all kinds of local applications, milked and massaged, where regular sexual intercourse is all that is necessary."[4]

Stricture as a sequel of gonorrhea or other causes, by producing reflex irritation and hyperemia of the posterior urethra and prostate, may finally result in impotence. Strictures are also due to onanism—Vecki states that in his experience 13% of all strictures are due to onanism. Otis traces 9% of all cases of stricture to that practice, with which Ricord and others agree.

Mode[3] states: "I have good reasons to believe that the pernicious habit of self-abuse is a much more frequent cause of stricture than is generally supposed."

In some persons there is a natural predisposition to neurasthenia. Beard[6] states that the causes of sexual neurasthenia are unfavorable social conditions, sexual excesses, grief, even excessive joy, unlooked for or unusual good fortune, as coming into possession of a large sum of money, and even climatic influences, but above all he believes that the most pronounced and predisposing causal force is modern civilization, in regard to its wants and claims, that are increasing more day by day.

Sexual weakness may also be inherited.

In regard to climatic influences, it is interesting to note the effect of tropical climates and that of some of our Southwestern States, where there is an abundance of sunshine, upon certain individuals, particularly blondes; the absence of pigment in the skin is supposed to permit this effect by the sun. These individuals are apt to become pronounced neurasthenics, and some of them impotent. While in tropical Mexico I was able to note this effect upon the foreigners resident there.

Very unusual cases of sexual anesthesia, a few of which are on record, where the individual has never experiencd any desire or sensation, and whose organs are capable of no excitement, and a few others who, while capable of erection and ejaculation, never experience any desire or sensation and are incapable of telling at which moment the orgasm takes place. Of this latter class of sexual anesthesia perverts there are all grades and kinds, some lacking one sensation, others another.

Irritable weakness, which is on the confines between diurnal pollutions and sexual neurasthenia, but differing from morbid pollution chiefly by the absence of any material change in the sexual organs, consists of a sexual irritation, which is generally of a high degree, but with which erection does not keep pace, for erection is either incomplete to start with or it becomes complete only after long exertion. In either case, however, ejaculation is precipitate and takes place even before introduction has occurred.[4]

Impotence is very frequently entirely imaginary or psychical, although it may be based upon existing lesions. Thus, too small a penis, occasional nocturnal seminal losses, stricture, tight prepuce, varicocele, gleety discharges, neuralgia of the testes, not infrequently restrain erection through fear of inability to penetrate or of increasing the existing trouble.

Regarding continence and its effects on potency, authorities differ widely on this point, some, I think, influenced by the moral view of the question, but as I am considering causes I wish to consider it fairly for what it is worth and will give the views pro and con. Many hold that the individual is unquestionably in better health when all the bodily functions are normally exercised, and the best means to preserve this function, as all others, is its normal exercise, when it can be retained until physiologically checked by the progress of age, and, as medical men, we must consider these things, as well as others which add to the health, happiness and contentment of the individual, or frequently mar what would otherwise have been a happy life. Not only excessive indulgence, but prolonged continence, may cause impotence. Prince A. Morrow[5] says that "the exercise of the sexual organs within certain bounds undoubtedly has the effect of strengthening, invigorating and preserving them in their full integrity." Continence may be good advice to give and is practiced by many from moral reasons; but absolute continence is frequently a cause of impotence. I do not mean that I disapprove of continence for the unmarried man or that I would give the opposite advice, as this is a matter largely for the individual to decide and upon which we are rarely consulted; but in dealing with causes we must consider the effects of prolonged disuse upon these parts. Continence may not be a hardship for the intellectual man, for many have lived without it and the world has been made better by them. Sir Isaac Newton is a notable example. But all of our patients are not of this type and many demand that their sexual needs be considered, and as I am not dealing with sexual hygiene, prophylaxis or the degrading moral influence of extra-matrimonial coitus, I must mention this effect.

The sperm once formed, if not expelled in a normal way, may at first check and finally arrest the further production of new semen, and this function may not be easily aroused again.[4]

The above are the opinions of Vecki, Kraft-Ebing, Hammond, Gross, and implied, if not expressed, opinion of Morrow, and concurred in by many others. On the other hand, I wish to quote a contrary opinion from James Scott,[2] who says that "with all the force that any knowledge I possess can give, and with any authority I may have, I assert, as the result of long observation and consideration of facts of every kind, that no man was ever yet in the slightest degree or way the better for incontinence; that for it every man must be worse morally and that most are worse physically, and in no small number the result is and ever will be utter physical shipwreck on one of the many rocks, sharp, jagged-edged, or on one of the many banks of festering slime that are about his course, and which no care can possibly avoid. And I am sure, further, that no man was ever yet anything but the better for perfect continence." This is certainly prudent advice to give from a moral or hygienic point of view, and we cannot help but admire his lofty ideals, and may choose to follow it ourselves, but with the majority of our patients, whose thoughts cannot be controlled, this will not do. I have tried it with them and it has failed, and most writers, some of whom I have quoted, hold the opposite opinion.

The effects of prolonged continence, and particularly where the thoughts are not controlled, is that of unrelieved congestion with its results, to which I have referred.

PATHOLOGY—Externally there is very little wrong to discover in some cases, while in others the external genitals show various degrees of flaccidity, shrinkage and paleness.

Continued investigation has proved that the various diseases of the sexual functions of man are not to be reduced to affections of the nervous apparatus exclusively, but they may also be dependent on structural disease.

Endoscopic examination of the urethra reveals, in most cases, different degrees of paleness of the mucosa, and in nearly all cases that are associated with involuntary loss of sperm various degrees of inflammation of the colliculus seminalis are discovered.

We observe hyperemia, catarrhal swelling and hypertrophy of the colliculus seminalis.

Hyperemia is almost constantly met with in onanism, while patients affected with spermatorrhea are affected with various degrees of catarrh of the colliculus seminalis.[4] It is natural to conclude that in these conditions relaxation of the ejaculatory ducts exists, with lack of control, permitting the easy escape of semen.

Sometimes, though very little inflammation may be found, the posterior urethra and colliculus seminalis may be hyperesthetic and very sensitive to any mechanical contact. I have met these patients, who, after a mild application to these diseased parts, would have a pollution before they left the office or shortly after, sometimes at the next urination. They have always told me that there was no sensation connected with the loss.

PROGNOSIS—In anatomical conditions which interfere with or prevent the sexual act, the prognosis is, of course, bad, unless these conditions can be remedied surgically.

The prognosis in the functional cases frequently depends upon the physician's ability to gain and hold the patient's confidence and secure his strict compliance with directions. In those cases of onanism and other abuses or excesses, where the habit cannot be stopped, the prognosis is also unfavorable; also in those cases of persistent pollutions or spermatorrhea which cannot be controlled. The outlook is always more favorable when the sexual neurasthenia is due to structural change, as stricture, posterior urethritis, prostatitis, cystitis, etc., than when the neurasthenia is an independent disorder, in which cases relief is not so easily obtained. The prognosis is also bad when the trouble is the result of nervous or spinal disease or constitutional disorders. The prognosis is also relatively more unfavorable as the subject approaches the age limit, at which we would normally expect a subsidence of these powers; the same condition which might be easily cured in a youth with return of function might be incurable in a man of 50. When due to constitutional disease, relief depends upon the ability to cure these affections. However, there are few persons impotent from any cause, unless it be age, who cannot be much improved, if not entirely cured, by appropriate treatment judiciously carried out.

TREATMENT—First of all, the sexual hygiene must be regulated, abstinence for a while insisted upon; other habits and unfavorable conditions corrected or modified, as the drug addictions, the abuse of tobacco and alcohol. Conditions which cause or help to keep up pollutions or spermatorrhea must be relieved, as pruritis genitalis, or eczema of these parts, ascarides, phimosis, stricture, hemorrhoids or other rectal disease; hyperemia of the pelvic organs, bladder or urethra caused by some abdominal stasis or constipation, must be removed.

For the treatment of hyperesthesia, congestion or inflammation of the posterior urethra or colliculus seminalis, the judicious use of sounds and instillations usually suffice to effect a cure. In the use of the sound it is not necessary to use as large a one as will pass, but only one that can pass easily; if the largest size the urethra is capable of accommodating is a 28 French, then a 25 or 26 French will answer. It is the mere contact, mechanical influence or passage of the sound that is needed and it is not necessary to allow it to remain in any time; simply pass it and remove it. These treatments may be resorted to to start with twice a week; later, every other day, which should be sufficiently often; but some few cases seem to do better when treated daily. It is best both before and after the use of sounds or any urethral instrumentation to resort to thorough through and through irrigation, first cleansing the anterior urethra by the use of a dilute silver nitrate solution, 1 to 2000, or boracic acid 2 to 3%; but this is not absolutely necessary if you are sure of your asepsis and are not dealing with a case the result of gonorrhea.

The relief of these conditions under the sound is frequently very rapid. A urethra which is almost intolerant of the sound the first time may after a few treatments take it with ease.

Sometimes the use of the sound alone suffices for a cure, but it is well to use a few instillations of 10 to 20 minims or from ½ to 1% or stronger silver nitrate into the posterior urethra, instilling it with a deep urethral syringe, such as a Keyes or Ultzmann, or these can be alternated with the use of the sound. The treatment in these cases may last from a week to several months or longer. Occasionally the use of Winternitz's psychophor or cooling sound may be useful. This is particularly likely to be so if there is any neuralgia associated with the hyperesthesia.

Injections of cold water into the urethra are sometimes a benefit, but in cases where this is thought to be useful the psychophor is to be preferred, for in addition to the cooling influence produced by the water circulating through the sound, we have its mechanical influence the same as with an ordinary bougie, and its cooling effects can be regulated according to the duration of the application from a stimulating effect when very short to a depressing or antiphlogistic action if longer continued.

In spermatorrhea, pollutions and disease of the veru montanum, Lallemand was the first surgeon of note to undertake the serious study and treatment of these conditions, and his method of cauterizing the colliculus seminalis with the silver nitrate stick in a specially devised carrier was long practiced, but is now, I believe, rarely used. Its use, as might be supposed, causes severe pain until the inflammation it produced subsided.

When cauterization of these parts is now needed it can be made easily through the urethroscope, using solutions of silver nitrate 3 to 10%, or stronger, if needed, and the application can be absolutely confined to the part under treatment. These applications occasionally made, together with the use of the sound and instillations, will usually cure these conditions.

In the treatment of nocturnal pollutions, I have had occasion to use, with benefit, a suggestion of Dr. Halsey's, which is to empty the rectum and lower bowel (before retiring) by an enema, thus relieving congestion of these parts and any possible irritating effect the contents of the bowel may have. It is possible, too, that the injections have a direct sedative effect

To sum up the results of my experience in the management of abnormal seminal losses, I may add that the steel bougie, bromide of potash and atropia are especially adapted to cases of nocturnal emissions and that electricity, ergot and strychnin are the most reliable agents in durnal pollutons and spermarrhagia.

In the treatment of cases of onanism, where the desire for the habit is very strong, and in cases of pollutions, the initial use of bromide has been useful in my hands to relieve the irritation while the local treatment is going on, continuing it as long as the symptoms recur, or until the posterior urethra appears normal under urethroscopic examination; then should the normal desires not return, the administration of phosphorus in small doses, 1/100 of a grain three times a day, alone or combined with strychnin, or what seems to act better sometimes, strychnin and zinc phosphide. Vecki recommends the use of somatose in conditions where the secretion is defective. I have had no experience with it, but have noticed its stimulating effect on the mammary glands of nursing mothers, and owing to the close similarity of these organs its use seems rational.

"Whether there is anemia, flaccidity and coldness of the genitals, atropia sometimes does good by overcoming the contraction of the muscular fibres of the trabeculæ of the erectile bodies and to induce dilation of the arterioles and an increased flow of blood through the organs. Its good effects are also evident by the diminution of the number or the entire cessation of the nocturnal pollutions and prostatic discharges."[3]

In conditions where irritable weakness, neurasthenia or psychoses play any part, constitutional treatment is usually essential. To those who can afford it, a short trip away or a sea voyage is very beneficial. The change of scene and thoughts, with the rest and recreation, frequently work wonders in some cases and cannot help but be of some benefit to all.

Sea bathing and river bathing are very useful in their tonic and stimulating effects. They should be indulged in only a short while at each immersion and never to exhaustion. Their action is due to the stimulating effect of the waves and moving water upon the body and to the tonic effect of the cold; consequently, moving water is better than still water and cool water than warm. Shower baths and the cold douche to the spine can be used at home with benefit.

The same results may be had from sulphurous, thermal and carbonic acid waters, as at Nauheim, where the aphrodisiac effect has been noticed along with the other improvements in patients visiting there; here the effect is due to the cutaneous irritation.

Various forms of electricity have been used with benefit, both for their constitutional and physical effects, static electricity in psychical and neurasthenic subjects, or the local use of galvanism in atonic conditions.

Organotherapy has been used, as Brown-Sequard's fluid; and claimed to be beneficial by some, but I do not think with any better results than a properly directed tonic treatment.

In paralytic spermatorrhea and aphrodisia of neurasthenics, Vecki has recommended cornutin citricum, grain 1/20 three times a day.

Suspension, a heroic form of treatment, has been productive of benefit in the hands of some; thus Vecki says: "The therapeutics of impotence have been greatly enriched by Motschutkovsky, who, while applying Sayre's corsets, noticed that the body lengthened during suspension; repeated measurements proved that this lengthening is due to the stretching of the vertebral column and varies between 2½ to 5 centimetres. This led Motschutkovsky to the idea of trying suspension in diseases of the spinal cord. The result was excellent; several troublesome symptoms vanished during the treatment. Of chief interest for us in this experimentation is the circumstance that in every case a certain number of suspensions removed all the pre-existing disturbances in the sexual feelings and power. In Charcot's clinic in Paris the same fact was established, along with decided improvement in functional diseases of the bladder, so often accompanying tabes; and also the cure of neurasthenic impotence. Bernhard reports a case in which, after 19 suspensions, erection and pollution reappeared, after having been absent for over a year.

"I have treated with suspension numerous patients threatened with paralytic impotence and in several cases obtained considerable improvement. After a few suspensions, erection and libido partially returned. I never noticed lasting results, however. Everything returned to the old state a few days after the cessation of the suspension and, moreover, the suspensions themselves lost their efficacy after a few weeks. These suspensions in paralytic impotence may be compared to one of the last lashes given to a jaded beast of burden.

"Since, however, suspensions have had some effect on paralytic impotence, a disease in which therapeutics is usually powerless, it was certainly to be expected that they would produce better or more satisfactory results in forms of impotence that are easier to cure. Indeed, I have obtained very favorable results and sometimes a perfect cure in various cases of sexual neurasthenia."[4]

In psychical impotency, where the condition exists only in the mind of the individual, through excessive modesty, fear of being mortified by failure or some other notion, some writers have recommended securing the co-operation of the other party, when after some acquaintance and encouragement success has ben obtained, and after once successful there is usually no further trouble; on this ground, marriage has been recommended, but it would seem uncertain advice to give, unless one were sure of the patient's ability; for in the event of failure the harm could not be undone and the condition certainly be aggravated and other troubles added.

Inherited sexual weakness has also to be considered, but treatment here is very difficult. In these cases and in atonic conditions massage of the prostate will help by its toning influence in conjunction with constitutional treatment.

Various mechanical supports have been devised to aid intromission of the organ—some that compress the dorsal vein, preventing the too free escape of blood, when this is thought to be the cause—but I do not think I would ever recommend these devices, as they are likely to aggravate some of the conditions, particularly those cases of irritable weakness.

Hypnotism has also been used by some, who claim benefit from it.

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DISCUSSION.

DR. CHASSAIGNAC said that the subject was so vast that it is only possible to cover it in a large number of papers or even text-books, and the essayist deserved great credit for saying so much in a single paper. The most important point is to find and locate the cause, which Dr. Chassaignac divides into three classes: 1st. The physical ones; 2d. the psychical; the 3d and largest class, a combination of the other two. He wished to enter a protest against the statement made by Dr. Allen that stripping of the prostate and seminal vesicles was not necessary, as sexual intercourse was preferable and accomplished as much. He knew that this action was not the same, for massage not only emptied the seminal vesicles and did good in that way, but it was a stimulant towards healing and absorption and from that was derived the greatest benefit. Cases of great interest are the emotional or psychical ones; they are very troublesome and the patients far more difficult to handle than those with physical impotence. In the treatment of these cases one of the most useful schemes to employ is to gain the confidence of the patient and to prohibit absolutely any attempt at sexual intercourse; this not only prevents the failures which are sure to occur, and each time makes our patient feel worse and more despondent, but because we can expect him to break loose and disobey after the necessary rest; he will admit to us, when he returns, in a half guilty, half triumphant manner, tha the has disobeyed our instructions, but that everything was all right, when we must explain that this was our purpose and expectation and that he is cured.

Dr. Sexton said that the essayist failed to mention metastasis from mumps as a cause of impotence. Dr. Sexton had treated such a case with all the aphrodisiac pills and solutions with no improvement whatever. In cases of impotence from other causes, as stricture, which could be dilated, local inflammation which could be improved by local treatment or applications, or when from some constitutional disturbances as syphilis, malaria, neurasthenia, etc., which could be built up by proper remedies, he had experienced some better results. As a rule his experience of treating impotency by drugs only was unsatisfactory. Local treatment, massage, etc., had been more promising. He could not allow to go unchallenged the remark made by the essayist that there was no such a thing as platonic love. He certainly knew of the love of innocent girls where there was no such thing as sexual thought or desire in their affections.

Dr. Nelken said that Dr. Allen deserved credit for bringing up a subject the discussion of which the majority of physicians preferred to avoid. The paper was fairly exhaustive and the subject treated as well as it could be in so little space.

He objected to the term "onanism" when masturbation was meant. Biblical readers knew that the sin of Onan was not masturbation. He thought that the importance of masturbation as a causative factor of true impotence had been exaggerated by the essayist. Observation of the lower animals suggested that masturbation might be considered as a vice inherited in the process of evolution. Most men had masturbated at some time in their lives and suffered no harmful results unless their minds were disturbed by the reading of quack literature.

Melancholia had been referred to as one of the results of impotence. He believed that frequently the impotence was the result and not the cause of insanity. He had seen one case of suicide in a melancholic in whom impotence was the subject of his monomania. Dr. Nelken laid stress on ungratified sexual excitement as a common causative factor of impotence. The large number of drugs and methods in the treatment of impotence showed the importance of the psychic element in a large number of cases, for they are benefited or cured by anything which makes sufficient mental impression. He agreed with Dr. Chassaignac that sexual intercourse was not a substitute for massage in pathological conditions of the prostate and seminal vesicles.

Dr. Allen, in closing, thanked those who took part in the discussion for their remarks. He did not mean to say that he recommended sexual intercourse for congestion of the prostate and seminal vesicles dependent upon infectious processes, but only for those cases of congestion caused by ungratified sexual excitement.

Reports of Cases.

Dr. Samuel Logan reported:

A Case of Tetanus Treated by the Intraspinal Injection of 25% Solution of Magnesium Sulphate.

Synopsis of Case 1.

Boy, Aged 11. Date of injury, January 1. Treatment: 1st *symptoms* on January 9, p. m. (9 days). Brought to amphitheatre, wound dressed and 50 c.c. antitetanic intraspinally. (Dana.) Probable diagnosis of tetanus.

First treatment: Bromide (gr. xxx) and chloral (gr. xv.) till 10 a. m. January 11 (36 hours after first symptom), at this time convulsions when handled.

First injections, $MgSo_4$, ʒi of 25% solution, intraspinally. Rigidity during deep anesthesia. Slowness of injection (10 minutes).

50 c.c again (10 c.c each in sciatics, 10 c.c. in brachial plexuses, and 10 c.c. around wound). Wound dressed after more cleansing. Forty minutes after injection complete relaxation. Pulse steadily going up. Relaxation for 12 hours and 45 minutes, then return of muscular twitchings.

Trouble with respiration 4½ hours after injection. Bronchorrhea. Atropin 1/150 grain.

Examination at this time as to relaxation, consciousness, etc. Pulse steadily going up.

Relaxation for 12 hours and 45 minutes, then return of muscular twitchings.

Second injection 24 hours after first. Pulse at that time 150; temp. 120; rigidity; 50 minims (in 10 minutes), of 25% $MgSo_4$. Thirty-five minutes afterwards, relaxation complete.

Respiratory trouble three hours after injection of same character as first. Pulse at this time, 168.

Atropin, gr. 1/150, and digitalin, gr. 1/100 ordered.

Marked sinking, with death that night at 3:50 a. m. (40 hours and 50 minutes after first injection, and 80 hours after admittance). Respiration continued for 20 minutes after pulse became imperceptible in large vessels.

Temp. p. m., 108 (rectum).

No postmortem.

POINTS: 1. Control of convulsions.

2. Respiratory disturbance.

3. High temperature with slight muscular exertion.

4. Wearing out of the heart, *not* due to muscular exertion.

5. Failure of heart first.

6. Death in perfectly relaxed condition.

SYNOPSIS OF SECOND CASE.

Occurred in practice of Dr. Matas, who suggested use of magnesium sulphate by Dr. Urban Maes, through whose courtesy it is reported.

—— ———. Female. Age 24. Personal and family history negative as regards present illness.

On Feb. 2, 1906, patient was vaccinated under the strictest aseptic precautions and the wound sealed aseptically. Seventeen days later first symptoms of tetanus, stiffness of neck and jaws noted by patient. Dressing on arm immediately removed, wound cleaned and new bichloride applied. Vaccination had taken. One hundred c.c. of antitetanic serum given subcutaneously as soon as it could be procured. Rapid increase of symptoms.

Use of 60 minims of 25% solution of magnesium sulphate (sterilized by boiling) 30 hours after first symptoms were noted. Wide excision of wound area at same time, with a saturation of it with dry antitetanic serum. No result noticed, and at family's request, seventeen hours later, a second injection of like quantity made, again with no result. The patient died fifty hours after initial symptoms had appeared, the attack being fulminating in type, and the magnesium solution failing to have any effect whatever.

Discussion.

Dr. Maes said, by way of comparison, that his case showed no improvement after the intraspinal injection of magnesium sulphate solution. He saw the case fourteen hours after the onset of symptoms and it was a most violent one. The patient died from respiratory paralysis and not from heart failure as in the case reported by Dr. Logan.

When the patient was first seen even the superficial muscles were in a state of tetanic contraction. He added that Dr. Matas had noticed complete motor paralysis lasting several hours following the intraspinal injection of stovain (5 decigrams). Dr. Maes used stovain in a second case in the service of Dr. Matas and noticed anesthesia with motor paralysis extending to the mammary line and lasting several hours (9:30 a. m. to 4 p. m.). He suggested on account of the similarity of action between stovain and magnesium sulphate in these instances, both causing anesthesia with motor paralysis when introduced into the spinal canal, that stovain might be employed in the treatment of tetanus. He also reported that Chaput in his report of a large series of cases had noticed motor as well as sensory paralysis to be a constant phenomenon following the use of stovain in the spinal canal.

Dr. Gessner said it was unusual to see a violent case of tetanus dying in thirty hours, where the period of incubation had been seventeen days. He believed that there might have been another and later infection.

Dr. Maes said he had examined the patient carefully and found no other wound. The wound was a vaccination one, and it was possible that it might have been infected by slightly raising the dressing to examine the wound. This he had reason to believe was done frequently. The vaccination had taken.

Dr. Dabney asked what vaccine points were used?

Dr. Maes replied that Parke, Davis & Co. vaccine points had been used. A young lady friend of his patient, employed at the same office, was vaccinated at the same time, with a point from the same lot. The vaccination did not take and a subsequent vaccination was also negative.

Dr. H. P. Jones said he had one of the points from the same lot under investigation and promised later to give to the Society the report of the bacteriologist.

Dr. Arthur Nolte read the following:

Answer to Dr. Walter Wyman's Communication in the New Orleans Medical and Surgical Journal of March, 1906.

Mr. Chairman and Members of the Orleans Parish Medical Society:

Gentlemen—In the March number of the New Orleans Medical and Surgical Journal there is published a communication from Dr. Walter Wyman, Surgeon General, P. H. and M. H. Service, in which he states that I made a number of misstatements in my paper on "State Quarantine," read at a meeting of this Society November 11, 1905, and that he considers it his duty to correct these statements.

He quotes several statements of mine and makes an attempt to correct them.

Dr. Wyman's efforts at correction might, to the casual reader, or to one entirely ignorant of the subject matter, seem to have some force, but if any one will take the trouble to examine below the surface he will find that so far from refuting my statements he really confirms them.

I will take up seriatim the statements which he claims are incorrect: 1st. I stated that the Marine Hospital Service was established in reconstruction period during Republican regime, etc Dr. Wyman says it was established in 1798, *but was reorganized in 1870* *by an act of Congress;* in other words, received its official life in 1870. Now that attempt at correction might really mislead some people, but not many. Surely no one from the South need be told that 1870 was right in the midst of the reconstruction period; the days when Louisiana and Mississippi and the Carolinas were under the "carpet-bag rule" and had no representation in that Congress which created this Marine Hospital Service. It is really hard to believe that Dr. Wyman did not know that the year 1870 was part of the reconstruction period.

As to my statement that medical men could get into the service by passing a not difficult examination, and men even got in without a diploma of graduation, Dr. Wyman says he knows of only one man who entered the service without a diploma. This admission on his part shows that the possession of a diploma was not one of the requirements for entrance and certainly proves my statement that it was not a difficult thing from a medical point of view to enter the Marine Hospital Service.

Next Dr. Wyman quotes from my paper: "In August, 1893, yellow fever was actually brought into the town of Brunswick, Ga., by the M. H. S., and the epidemic which resulted therefrom lasted until November."

Dr. Wyman says this is incorrect. Nevertheless it is a well authenticated fact and a matter of record that a surgeon of the M. H. S., Branham by name, sick with yellow fever, was brought into Brunswick, Ga., by the M. H. S. authorities, on a steamer crowded with passengers, during August, 1893, and an epidemic followed.

Next in my paper I stated that yellow fever first made its appearance in this country at Ocean Springs, Miss., in 1897, having been brought in by Cuban filibusters through the lines of the M. H. S. at Ship Island. Dr. Wyman says that this "old story has been repeatedly proven incorrect and that no evidence has been brought showing that the Cuban filibusters brought the fever to Ocean Springs."

Dr. Wyman is in error. Any amount of evidence has been brought to prove my statements and I am somewhat surprised to learn that Dr. Wyman does not remember the evidence collected, edited, and printed in pamphlet form, by Dr. Edmond Souchon in an article entitled the "True Origin of the Epidemic of Yellow Fever." This article by Dr. Souchon was written in reply to one by Dr. J. H.

White of the M. H. S., entitled "True Origin of the Epidemic of 1897."

Dr. Wyman's attention was called to the above article repeatedly and his memory is very bad indeed as to the fact. Dr. Souchon presents in his article the very strongest evidence from Dr. C. P. Wilkinson, resident physician at the Mississippi River Quarantine Station, and Mr. J. M. Leveque, at that time with the *Picayune,* but now editor of the *Harlequin,* that yellow fever was brought to Ocean Springs, Miss., from Cuba and that a well developed case of yellow fever existed in the house of a Mrs. Gonzales, a Cuban sympathizer, at Ocean Springs, as early as the month of March, 1897. The Marine Hospital Service had endeavored to show that yellow fever was introduced into Ocean Springs by a man named Thomas Shannahan; that Shannahan had come from Guatemala to the Mississippi River Quarantine Station and then infected Ocean Springs.

Dr. Souchon in his article proved clearly the absolute impossibility of this contention of the M. H. S.

Next Dr. Wyman quotes: "The Marine Hospital officer at Belize gave clean bills of health from that place from the beginning of this season, April 1 to May 24, nearly two months, by which time yellow fever was epidemic in Belize." Dr. Wyman admits the correctness of the above and merely says "how many cases there were preceding the first case it is impossible to determine." In other words, he admits all that I charge—viz., that yellow fever existed in Belize long before the officer of his service reported it. I made no attempt to point out *why* the M. H. S. officer had failed to report yellow fever until it was epidemic at Belize, but merely stated that fact that he did fail. It is no defense for Dr. Wyman to say that their officer was originally from New Orleans. At this point I desire to say that I knew that officer, Dr. W. H. Carson, very well, and have always had the most friendly feeling for him; that I believe that any error that he may have made was from the head and not from the heart.

As regards my statement that the M. H. S. had issued clean bills of health from San Francisco in 1900, I would say that I am perfectly well aware that the M. H. S. does not directly issue a bill of health from any port of continental United States, but such bill of health is issued by the Customhouse of that port, which is a part of the same department of the Government and receives its information from the M. H. S. officer of that port.

Next I charged that the commission sent out by the Treasury Department to San Francisco to investigate the existence or non-existence of plague and report thereon absolutely refused to make that report, for political reasons. I proved this by Dr. Wyman's own words in the letter which I quoted which was written and signed by him. Dr. Wyman in his communication goes on at great length in an attempt to show by referring to Public Health Reports of such and such a date and such and such a page that the report of that commission was made public, but he knows very well that that report was not made public until long after the facts ceased to be of any interest or use.

Next Dr. Wyman says: "Dr. Nolte in his paper intimates that the vessel named the *Curacoa* carried the plague from San Francisco to Mazatlan, Mexico. This has never been proven and the presumption is that the plague was not transmitted from the United States at all." In reply I would say that Dr. Liceaga, President of the Superior Board of Health of Mexico, in an article read before the American Public Health Association, charged, and maintained by relating facts connected therewith, that plague was transmitted in the manner mentioned in my paper.

I have taken up the various points which Dr. Wyman says I was incorrect in and I believe I have shown that I was correct.

(Signed) ARTHUR NOLTE.

MEETING OF MARCH 24, 1906.

DR. BEVERLY E. WARNER gave a talk on "HIS RECENT TRIP TO CENTRAL AMERICA." (Copy not furnished to Publication Committee.)

DR. J. H. WHITE gave a talk on "CURRENT TOPICS." (Copy not furnished to Publication Committee.)

Dr. L. G. LeBeuf related *A Case of Renal Calculus.*

Mrs. DeHarnell, white female, age 35 years. One forceps delivery thirteen years ago. Another labor podalic version six years ago, with stillborn child—a perfect monster in size, 12½ pounds. Became pregnant ten months ago. During pregnancy was continually sick, in bed at one time for three months. Pain in back and right side, over region of right kidney. Never passed any blood—no pus. Urine examined showed great quantity of phosphates—no microscopic examination made. Treatment: Rest, codein, acid boracic. When labor set in on February 15 it proceeded normally for two or three hours, then complete inertia of uterus took place, so high forceps, Holt's, were applied without much difficulty, head was brought down to perineum and in a few moments later a large nine pound female child delivered. Patient did very well, no temperature until 14th day, when she began having a continuous temperature, 103 and 104, with excruciating pains in right lumbar region. Lochiæ normal, examination revealed no sign of sepsis. High up to the right uterus through Sim's speculum, and by digital examination I could feel a fluctuating mass which I took to be a pelvic abscess. In two or three days I examined here again. Mass or tumor was very painful to touch and growing larger. During night of the 1st of March she had a violent chill, and suddenly pain was relieved at once. Tumor in pelvis had also disappeared. Next day and for two or three days following she passed considerable pus and blood and flocculations of fibrin and mucus. The third night, after this sudden sensation, when temperature had been normal twenty-four hours, she was not able to void her urine. When sent for again she was in great pain—bladder very much distended and pulse quite rapid. She said she had not voided her urine for over twenty hours. I examined her carefully and attempting to pass a sound into her bladder I found an obstruction in her urethra. With very little dilatation of canal, I was able to deliver this large oblong renal stone. Undoubtedly this stone had been lodged or embedded in ureter and I judge that my forcible delivery of head of fetus with forceps had helped to displace the stone to nearly the fundus of bladder and the fluctuation and tumor felt may have been an abscess formed around stone during time of its descent to the bladder.

DISCUSSION.

DR. GESSNER: Dr. LeBeuf's patient had previously been under his treatment and her case was especially interesting. A peculiar feature was the pain which shifted from one side to the other; at first she complained of pain on the left side and then on the right. He prescribed urotropin in large quantities of water, and on that treatment the pain left her. Examination of the urine by the New Orleans clinical laboratory showed no pus, blood or other ingredient the presence of which would establish the diagnosis of stone.

DR. SALATICH reported *A Case of Salivary Calculi* occurring in Dr. E. S. Lewis's Clinic.—White female, aged 29. Fourteen years ago passed a salivary stone from left Wharton's duct. Since then and including the last one, she has passed three more. The last was as large as a red bean. Several abscesses had developed and the patient was being treated for reflex middle ear disease. A probe could be passed easily through the duct and would scratch the stone. An incision was made and the latter removed.

DISCUSSION.

DR. LAZARD wanted to know from where the incision had been made.

DR. SALATICH replied that the incision was made from within, by splitting the canal.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D.   ISADORE DYER, M. D.

Revision of the Medical Act.

Each member of the Louisiana State Medical Society has been sent a letter of appeal from the Chairman of the Council of that body, together with a copy of the proposed amendments to the medical law regulating the practice of medicine, surgery and midwifery in the State of Louisiana. Considerable thought and large discussion have been given to these amendments as now framed, and it is the duty of every medical man in the State of Louisiana to see to it that another session of the Legislature does not go by without their adoption.

Organization of the medical profession has as one of its chief aims the protection of the public and incidentally the protection of the medical profession itself. Unless the medical man individually constitutes himself a factor in the purposes of organization very little may be accomplished in furthering the ends for which organization has been perfected. During the last few years the Louisiana State Medical Society has grown into considerable importance in its relation to the public health, education, scientific advancement and the relation to malefactors against the privileges of the Guild itself. The public at this time is more broadly open to the necessities for its protection, as well as for the improvement in the personnel and quality of the medical profession itself.

The act in its proposed amendments covers some of the vital issues which have been raised by the State Board of Medical Examiners in their relation to the practice of medicine and midwifery in the State of Louisiana. We presume that many of our readers have carefully reviewed the copy of the proposed act, but it may be wise to dwell upon the important points therein covered.

It is proposed to establish a reciprocity clause which will entitle any qualified practitioner of medicine licensed by a Board requiring the same grade and standard as the one in this State to practice upon proper registration under the law.

It is also proposed to broaden the application of the term "practicing medicine" so as to reach the many parasites who infringe upon the privileges of the qualified practitioner and who impose upon an ignorant or stultified public under the pretension of qualified agencies not usually embraced in a medical course. It further provides for a summary proceeding against offenders under trial by judge without intervention of jury.

It also provides for the dispensing of revenues under all contingencies which may arise.

To the members of the State Medical Society it may be a needless repetition for us to call attention to the importance of their interest in furthering the enactment of the amendments, but as the time is pressing, the meeting of the Legislature at hand, and the average practitioner of medicine busy enough to overlook the importance of individual action, we feel that any encouragement which we may give to the appeal of the council may serve some purpose. To this end the JOURNAL would urge that every member of the medical profession in the State of Louisiana see to it that his representative in the State Legislature is made to carry an intelligent idea of the purpose of the proposed act; further, that he should be made to feel that the act represents the sentiment of the particular section in which the individual physician resides; and that the act is the result of mature deliberation on the part of the representative body of the profession in the State of Louisiana, whose purposes are on a high plane, and aimed at purifying the practice of medicine to the extent that it shall be thoroughly legitimized in this State.

It is the more important that this effort should be strenuous on our part, as we can hope for little assistance at the hands of the daily press, who are largely interested in the maintenance of the very class of individuals aimed at, who contribute largely to the income of such publications through their advertising columns.

Finally, don't forget that the Legislature meets this month, and that the early reading of the act will mean its early consideration, and if your assistance is to be depended upon, whatever you do must be done NOW.

The Simplified Spelling Board.

The facility and adaptivity of the French language have qualified it peculiarly for international commerce, diplomacy and science of certain sorts. The Teutonic tongue has grown into certain fields of usefulness where exactness in terms requires fixed expression. Meanwhile no language has spread more broadly than the modern English, and in spite of its hybrid growth.

Every now and then some Utopian spirit has ventured an essay at a universal language, and each of these has started at essential principles in philologic roots. With one a Greek, another a Latin, another an Aryan, another an Hebraic, and yet another Anglic or Celtic origins have been studied and pruned to a possible usefulness.

Natural tendencies, however, are greater in force than even genius, and all of these have gone the way of Volapük, finally resting as curiosities in the archeologic museums.

Among modern languages, Spanish alone is true to essential principles of etymology, and the standard language of the Peninsula is governed by Academic rules which make new words part of the established language. But Spanish, even in its purity, is a derived language within limits of expansibility, and long ago suffered a severe nipping when the colonistic spirit of Spain came to its natural demise.

The whole world notes the aggressiveness of the English tongue, and gradually the impulse points to this as the universal speech of the future. The natural course of philologic development in the more modern tongue has grafted on the earlier and cardinal Anglo-Saxon roots a mass of adaptive words which have rapidly grown to be integral themselves. But with the broad license which this entailed, the result has been disastrous to the orthography as well as the orthoepy of the English language. Concomitantly with the vast development of the arts, sciences, commerce and civilization itself, bastard words have crept in, begotten by the press and a multitudinous mass of fiction writers catering to a none too particular public, either lay or secular; but, nevertheless, these words of broad slang or of technical application, pure or mongrel, have come to stay as parts of English speech.

Various and sundry endeavor has been made to amend, revise and purify modern English, but so far to no purpose.

At this time a movement has been born under the auspices of the Simplified Spelling Board, to the end that, by reducing irregular and difficult words to their simplest phonetic equivalents, some start may be made in rendering English more readily understood and, therefore, acquired by foreign students.

The movement has already gained considerable ground under the liberal patronage of Andrew Carnegie, and under the direct interest of leading English scholars in the country. Among these are to be named Brander Matthews, E. Benjamin Andrews, David J. Brewer, Nicholas Murray Butler, Samuel L. Clemens (Mark Twain), Richard Watson Gilder, Prof. William James, Prof. Thomas R. Lounsbury, Benj. E. Smith and a number of others, also notable. At their inceptive work considerable ridicule was cast upon the movement, under the misapprehension that an attempt was being made to revolutionize the present orthography at the expense of the language. The cartoonists of the weekly and cosmopolitan press found ample opportunity for their peculiar attacks. The movement has, however, survived, and it is a serious endeavor to a good end. Diphthongs of useless purpose, terminal syllables or letters of silent presence, and multiplied letters of no orthoepic value are to be discarded, and phonetic spelling substituted. Many of the innovations proposed are actually revivals of Shakspearian practice, and no less spirits than Spencer, Bacon, Johnson, Pope, Burns, Bunyan, Milton, Tennyson, Cowper, Scott and Lowell are related in their texts to the Simplified Spelling.

No specific attitude has been taken with regard to secular words, but the first move of the Board is to gain the co-operation of all persons interested in writing, and teaching the English language. With an established following of those earnest in the desire for simple spelling without sacrificing our mother tongue, the next move will be along allied special, as well as general, words.

With the practice at present common in medicine of creating new terms and words, a large field is open for innovation. Dr. George Gould in the original *Philadelphia Medical Journal* essayed somewhat in revised spelling, but he had small following. With some systematic rules, devised along logical lines, we may yet be able to read the same language in all our medical books and journals. With such words as *quinine* and *tannin, phthisis,* and *lysis, morbid* and *syphilide, haemorrhage* and *diarrhoea,* reduced to phonetic equivalents alike, we may hope to find a mean of intellectual commodity common to all professions and peoples, and no Babel in the horoscope of universal endeavor, prosperity or practice.

Louisiana State Society Meeting.

The JOURNAL will reach the members of the State Society just in time to remind them that they must complete their preparations for coming to the meeting.

The half rate fare makes it easier than usual from the point of expense, and there is no amount of sickness anywhere in the State to render it difficult for our brethren to absent themselves for three or four days.

On the other hand, the final arrangements for an aggressive effort to pass the medical practice act must be made, sanitary and health measures demand unusual consideration, and many scientific problems are ripe for discussion.

The general committees have so far done their work well, and the local arrangement committee has made all preparations for the comfort and pleasure of those in attendance.

The society must break the record once more. That it may do so now depends only upon sufficient individual effort on the part of the members.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of DR. F. W. PARHAM, Assisted by DR. F. LARUE, New Orleans.

NEW TECHNICS IN BREAST AMPUTATION—Two articles, well calculated to increase the surgeon's ability to deal with some of the technical problems in breast amputations for malignant diseases, have recently appeared; one by Murphy in the *New York Medical*

Journal, the other by Jabez N. Jackson, of Kansas City, in the *Journal of the American Medical Association.*

Jackson's operation consists in making the incisions so that a broad flap of skin is taken up from the front of the chest, the free edge being raised from the axilla, and the flap, when freed, being capable of being folded back across the opposite clavicle. An incision is first made beginning about an inch and a half below the middle of the clavicle in the sulcus between the deltoid and greater pectoral muscles. Thence it is carried in a straight line along this sulcus until it reaches the lower border of the pectoral fold as it terminates in the arm. Another incision starts here and is carried along under the margin of the pectoral fold, thence around the mamma forward and down to about the middle of the second line of incision. The ellipse about the mamma has its major axis directed obliquely from below upward and towards the opposite shoulder. When all these lines of incision shall have been dissected up and the diseased gland, axillary contents and muscles removed, the large quadrilateral flap of skin can be moved around towards the middle line and the large gap beautifully closed in without tension. It seems to us an admirable procedure, and can be adopted in all cases where the disease has not actually invaded this area of integument.

The suggestion of Murphy deals especially with the prevention of constriction of the vessels and nerves of the axilla, resulting from the formation of a cicatrix about them. Any of the thoraco-humeral muscles may be used for this purpose, either pectoral muscle, the latissimus or even the subscapularis. The technic consists in swinging a strip of one of these muscles, preferably the greater pectoral, attached at one end, around in such a way as completely to cover the axillary vessels and nerves. This also is an excellent suggestion to be carried out in cases where the radical operation does not demand the extirpation of all the muscular tissue that might be available.

In any case the arm is to be dressed in upward extension in plaster of Paris until healing takes place.

Department of Obstetrics and Gynecology.

In Charge of Dr. P. Michinard and Dr. C. J. Miller, of New Orleans.

The Uterus and Ovary of Neurasthenia—Robert L. Dickinson (*Med. Record*) sums up the treatment of the pelvic symptoms of neurasthenia as follows:

After relating the minor measures, the major measures consist of a careful study of the conditions of the patient's life. We plan such remodeling of the habits that each day she spends less nervous energy than she makes. Such radical changes in ridding her of special worry of strain, as by greatest effort of sacrifice, may be possible; such thoroughgoing training in outdoor life—first, by resting methods, if necessary, then by development of the muscular system; such a program of forced feeding and long sleeping, and healthful mental attitude and occupation as to constitute gradual but complete readjustment. These are to be preceded by operation in a very limited number of cases, such as tumors (*e. g.,* ovarian), growing and necessarily fatal, or exhausting hemorrhages, as from submucous fibroids, or extreme retroversion associated with endometritis that will not yield to lesser measures. But with the distinct understanding that the operation is to save life, or to initiate the cure, a first step to the more important measures above and attended with danger of prolonged nervous disturbance. Thus, in confirmed neurasthenia with pronounced pelvic symptoms, the hopefulness of the outlook depends not so much upon the operative cure of the few life endangering conditions as upon the measure of our success in persuading patients to live and work contentedly within the fences of their limitations; on happy mental occupation; on outdoor habit and outdoor hobby; on graduated muscular training and hydrotherapy; on regulated feeding and resting. What hospitals now are to major surgery, country and suburban sanatoria will become for the education of the sufferers from chronic illness.

Pernicious Vomiting of Pregnancy—J. Whitridge Williams' article (*Johns Hopkins Hospital Bulletin,* March, 1906) is an elaborate résumé of the subject, with certain original ideas as to the metabolic changes observed. The ordinary vomiting of pregnancy is common, about half the cases in private practice being affected; pernicious vomiting, however, is rarer, 2 in 4,500 hospital cases, 10 cases in private in two years.

Reflex vomiting is due to uterine malpositions, certain forms of endometritis, ovarian tumors, inflammations, diseases of the ovum (especially hydramnios and hydatid mole). Neurotic vomiting results from increased nervous irritability or decreased nervous control. Sometimes hysteria (either manifest or larval) is causative. It is possible that a mild toxemia may simulate some forms of nervous hyperemesis. Toxemic vomiting has been referred to toxins originating from the gastro-intestinal tract (as indicated by increase of indoxyl, skatoxyl, aromatic sulphates, etc., and by the presence of acetone, diacetic acid, peptone, etc., in the urine) from the fetus (syncytiotoxin theory of Veit), from altered or defective ovarian secretion (as shown by improvement when ovarian substance was given) and from hepatic lesions (found by Stone, Ewing and others). The last theory has constantly grown in prominence. Williams has found that in the toxic cases the ammonia coefficient of the urine is greatly increased. Whether this change, which must be regarded as evidence of insufficient oxidation, is due to destruction of liver cells, and consequent functional incapacity, or whether it is a manifestation of an acid intoxication, is not known. It is also not known whether the fetus or mother (intestine) produce the toxins. The gradations from ordinary morning sickness to pernicious vomiting may be imperceptible, but well defined cases can usually be readily differentiated. The pernicious type is either acute or chronic. Acute cases (always toxemic) run their course in 10 to 14 days, beginning with increasing vomiting, considerable prostration, little fever, and often nearly normal pulse. After a time the vomitus becomes "coffee ground" and is merely regurgitated. Torpor and coma develop, followed shortly by death. At the onset the urine is normal, toward the end it is dark, with albumin, blood and casts. There may be hyperpyrexia and jaundice. In the chronic forms, which may be toxic or neurotic, the vomiting continues for weeks or months, with consequent inanition and emaciation. The black vomit only appears in the terminal stage. The diagnosis of pernicious reflex vomiting is made by vaginal examination showing malpositions, tumors, too large a uterus, etc.; endometritis is indicated by the previous history of a brick-dust colored discharge from the cervix. Neurotic vomiting is differentiated from the toxemic type chiefly by the urine. A 24 hours' specimen is collected (preserved by a little chloroform), the total nitrogen determined by the Kjeldhal method, the amounts of urea and ammonia by the methods of Schoendorf and Schloessing. In normal pregnancy, or in neurotic vomiting, the ammonia coefficient is 3 to 5 per cent., in toxemia hyperemesis it rises to 32 to 46 per cent. Everything above 15 to 16 per cent. is suspicious. The examination requires 48 hours and can be performed only by an expert chemist. Leucin and tyrosin should also be looked for. Jaundice in a pregnant woman with hyperemesis is a grave sign and black vomit indicates a serious condition. In the later months a case first seen in coma may be hard to differentiate from eclampsia. Ewing regards eclampsia and acute yellow atrophy as the manifestations of the same toxemia. This is not borne out by the urine (which in eclampsia shows a decrease of the total nitrogen and usually in the urea coefficient, and no change in the ammonia coefficient). The liver lesions, too, are dissimilar—in eclampsia minute thromboses in the peripheral portal venules, in hyperemesis and acute yellow atrophy a central lobular degeneration. In the reflex and neurotic types the prognosis is excellent, but in rare cases inanition may be fatal. In the toxemic type the prognosis is grave—in the author's series, six cases with four deaths.

In the reflex type correction of malpositions, ablation of tumors, treatment of inflammations, emptying of the uterus of hydatid mole, etc., are to be done. In toxemic cases the uterus should be emptied as soon as the diagnosis is assured, then saline rectal injections, lavage of the stomach and rectal feeding should be resorted to. In the neurotic type vigorous moral lectures, rest cure or hospital supervision and isolation usually prove curative. Four cases of toxemic and three of neurotic vomiting are reported.

POST-OPERATIVE CYSTITIS—Dr. F. J. Taussig (*Surgery, Gynecology and Obstetrics*) states that the cause of cystitis in general has been investigated by such men as Melchior, Roosing, Guyon and others, but that form appearing after operation in women is only casually mentioned. Two-thirds of the author's patients were catheterized for over a week. Taussig claims that the general causes that produce post-operative cystitis in women are traumatism and infection. The one is incapable of producing cystitis without the other.

After full consideration of traumatism and the manner in which bacteria gain entrance into the bladder, as well as the means of prevention, the following conclusions are given:

1. Try to avoid urine retention by use of one or several of the following methods: Filling the bladder with sterile water at the conclusion of the operation, injecting boroglycerin solution into the full bladder, having the patient sit up out of bed as early as the nature of the operation will permit.
2. In the operation handle the bladder carefully and cover its denuded surface as well as possible before the close.
3. Prevent the introduction of germs from the urethra as far as possible by using a double catheter, such as devised by Rosenstein.
4. Internally, you may give urotropin, helmitol, etc.
5. Above all, wherever catheterization has to be continued for some time, irrigate the bladder each time with one or two pints of boric acid solution and continue such irrigations with each catheterization, not merely until the first spontaneous urination, but until there is no longer any residual urine.

Miscellaneous.

Parisian Medical Gossip.

THE APHORISMS OF HIPPOCRATES ACCORDING TO CABOTIN—THE VIEWS OF CATHERINE DE MEDICI ON PHLEBOTOMY—NEW MEDICINES—NEW SAVANTS—THE MICROBE OF AVARICE—BEHRING AND METCHNIKOFF—YELLOW FEVER IN HOLY WATER HAUNTED BY STEGOMYIA.

Translated by THOMAS C. MINOR, M. D., Cincinnati, Ohio.

In 1665 a lawyer in Parliament who answered to the name of Cabotin had the personal satisfaction of printing a work entitled *Commentary in Verse on the Aphorisms of Hippocrates.* Following the fashion of that epoch, renewed to-day by theatrical managers who speak of "our plays," Cabotin grouped in the first pages of his book fulsome eulogies addressed to his Parnassian contemporaries. In general these poets, except Richelet, who was author of a famed dictionary, were poor versifiers and now forgotten writers; they were professors of hyperbole—men who lingered as to versification around the threshold of those peculiar apostles of the seventeenth century. One of these thuriferies of those dithrambic and mirlitonesc times was the gazeteer Loret—a journalist titled by the Duchess de Longueville—a man distinguished for his enthusiasm for the works of Cabotin. It was this poet Loret who burst into rapturous song and who cried aloud:

All know in Paris and at Rome,
Hippocrates' name will never fade;
He taught his pupils, when at home,
How to make juleps and panade;
He cured, by art, each foul disease
And strove his patients all to please.

So it was Hippocrates who invented the medicinal juleps, of which the later mint julep of the House of Bourbon (Ky.) was an eighteenth century discovery. All these medicated juleps—save the latter—have now disappeared from the materia medica, and even the mint julep is in these modern days of degeneracy omitted from most works on therapeutics. "The mind of Cabotin," remarks Loret, "never fell below that of Hippocrates, and even *exceeded* that of the latter in capacity." Which remarks tends to show that Loret admired the Latin more than the Greek—a true French failing. It is impossible, at the present day, to imagine a flatter and more stupid book of medical poesy than the "commentary" of Cabotin on Hippocrates. It is written in the burlesque style of that Jack-in-the-tub poet, the great Scarron, who adopted the manner of many translated classical poets. Some poets of that time found this form of versification a good literary style for pleasantries of the satirical order. Cabotin could hardly have expected his manner of versification to be adopted by posterity, as one can easily imagine by the translation of even one passage on the benefits of a proper diet and hydrotherapy in acute affections.

In distorted rhyme of stub and twist metre, Cabotin writes:

In the ills that attack us,
Speak never of Bacchus.
Withdraw all that's bad in your meat—
Pheasant, partridge and quail,
Toothsome snipe, frog and snail,
Are exceedingly bad things to eat.
Beware Bacchus in toddy,
For it ruins your body.
Yet, wine courage gives to the dying.
Cut out dishes too hot,
Boiled or stewed in a pot.
Avoid, above all, food that is frying.

The continuation, in the same metrical fashion, may be omitted, as it will not be to the taste of the average English reader. The diet, in those days of the Parisian seventeenth century, for the sick was largely composed of "ptisanes." In an age when gluttony was prevalent, and the food ingested a sin against nature, it was no wonder that bleeding was all the medical rage—a fact that did not escape the satire of the immortal Moliere when he drew his delightful pen pictures of those celebrated physicians, the Tomes, Desbondres and Purgons of the Parisian medical faculty, characters that might be called by some later Moliere by the names of Doctors Serumtherapy, Proprietary Medicine and Old Man Germicide.

We have glanced through Cabotin's most extravagant poetical amplifications with more amusement than instruction. Cabotin makes some allusions to the distinguished comedian who was the most bitter satirist of medicine that ever lived, but he refrains from mentioning the immortal Moliere by name. Cabotin is full of grotesque anachronisms and introduces shotguns and French cooking into his commentaries on Hippocratic medicine:

Attila with joy partook of toasts,
Imbibing with wine his richest roasts;
So one day his soul took flight.
No gunshot wound,
No surgeon's knife,
Brought him to ground
Or took his life
When his soul passed into the Stygian night.

Gorged were the blood vessels of his brain
And all distended each heavy vein.
The doctors they bled
And Attila's soul fled.
Without consulting a medical "academee"
They practiced on him rude "phlebotomee."

No wonder then even Attila perished—even these rhymes of Cabotin had been fatal had Attila been a contemporary of Cabotin's. This all recalls those old French lines of a Parisian climber of the medical Parnassus, who wrote:

"Evacuez en diligence!
Foncez la lancette en ce bras
Si rond, si potele, et, si gras.
Evacuez en diligence;
Cette humeur, cette grosse panse
A fin que sans aucun danger,
L'Homme en apres puisse manger."

This passion for bleeding was a legacy of the twelfth century; yet, even in those days, there were august personages who would not be bled—even like that modern American patient who refused to be bled by the Parisian surgeon Doyen for a $30,000 fee. Going back to 164, the queen mother, Catherine de Medici, protested against the tyrannical rule of court physicians as regards phlebotomy. Catherine's daughter Elizabeth was the wife of Philip II., King of Spain. Elizabeth was not a strong woman, but the court physicians, faithful to the precepts of Hippocrates, bled the Spanish Queen on all occasions when she was pregnant and when she was over her confinements. Catherine protested very strongly against this medical custom of always bleeding. So we find a curious letter bearing date September 15, 1564, to M. Saint Sulpice, Ambassador of France to the court of Spain:

"Having learned from Lutaigne (valet de chambre of Charles IX.), who has just arrived, that my daughter Elizabeth continues well and even better now, as only a few scars remain, the ordinary signs of cure. God be praised! I hear that the doctors desire to return and bleed her again. I pray you—in my name—to enter a remonstrance, and tell them that a lady born in France (as my daughter was—and I know her constitution better than they do) can only be badly affected by these phlebotomies. Tell, on my part, too, the King of Spain, her husband, and likewise the Duke de Alba, too, I protest. I have written a letter to her physician, Vincent, that this is contrary to his opinion, yet he must not get angry at me, for I am rather pleased with him. It is merely to let the other doctors know," etc.

For the remainder, Catherine de Medici was an Italian; she made remedies and doctors as well, and even had her own pharmacopeia and her own astrologer, Ruggieri. But her science and her mysterious system of therapeutics, combined with the wise practice of sorcery, seem to have been forgotten by the medical poet Cabotin when he elaborated his ridiculous *Commentary in Verse on Hippocratic Medicine.* But enough of this parliamentary lawyer and gentleman given to medical verses, and let us turn to a different subject.

One may read in the *"Pensees"* of Pascal many savants accustomed to the principles of geometry lose their skill where these principles cannot be handled in an accurate manner. It is thus we find many Pasteurian doctors, so-called learned physicians (?), who do not understand the virulent products (microbian), patent sero-therapeutic remedies of the Rue Dutot, badly prepared and often blood poisoning serums. Voltaire observed: "Nothing is more ridiculous than a delicate physician unable to die of old age. They remind me of bald hair dressers who sell pomades and tonics to make the hair grow." Did you ever notice the number of bald-headed barbers? "Some two years ago," remarks Doctor Lecuyer, "I had the sorrow to lose my dear old father-in-law, Doctor Gene, aged 92 years. He was my predecessor here, and I practiced with him for 34 years. *He never took a dose of medicine in his life* and gave his patients as little as was possible. When I see young doctors of the modern school—the school of polypharmacy—make prescriptions out of new chemical remedies that destroy the best stomachs, it makes me laugh. As Guy Patin wrote, 'There is nothing new in either death or disease.' "

So let us even be gay.

Look at the new *melotherapic* treatment. They call it new, but it is ancient. The treatment of disease by music. Thus the violin is the musical remedy for hypochondriacs and the melancholics, while the bass viol does marvels and is a sovereign antidote in neurasthenia; so, too, is the clarionet, but it is a milder remedy. The harp is a specific for hysteria; the flute a marvelous prophylactic against incipient tuberculosis. The hautboy is a tonic and braces one up after financial losses. The French horn cures the delirium of persecution. The cornet-a-piston is fine for obesity and the bass drum banged on and marched with is a sure cure for locomotor ataxia. Doctor Gordon Da Costa, of Havana, it is who affirms all this musical medicine, and one must believe in all that comes from Havana, whether it is yellow fever from bilge water or from the toxic bed mosquito bred in the laboratories of the M. H. S.

Another doctor, one Birman, affirms, too—and all know the value of medical affirmations—that instruments made from the *wood of medicinal plants impress the curative properties of such plants on the player;* a flute made of cinchona wood will cure the most obstinate case of malarial fever, for instance. Music has been suggested as a sure cure for deafness. Tuba Mirum, from the requiem mass of Berlioz, with an ordinary orchestra of a hundred pieces and a chorus of a hundred singers, four brass bands and 24 trombones has been known to have cured several deaf people. Yet, sad to say, many deaf people cannot even hear the upper notes of Wagner's "Gottdammerung"—and it is just as well they never did. Metchinkoff has just gone over the work of a German savant named Schaudinn on the microbe of avarice. It seems to abound among great bacteriologists, who have more works for consumption to shortly be put on the market. Meantime the germ of the French pox hides in obscurity, like those other germs of smallpox, scarlatina, measles, etc., etc. Behring's remedies should be spelled Burying remedies. After the success of Koch's tuberculin and Marmoreck's serums, one wonders what next. But it appears that the immortal gods only communicate through Pasteurian sources. Shades of Peter, Trousseau and Jaccaud! Rise! You are not yet forgotten, as real medical men are not fools. We note with sadness, remarks D. H. Secuyer, of the *Journal de Medecine de Paris,* that Doctor Juan Guiteras, at New Orleans, on visiting the St. Louis cathedral, saw in the water contained in the benitier the dangerous infected mosquito, the famous, or rather infamous, stegomyia. The government, it is said, issued a sanitary ukase against holy water until such time as the fever disappeared. Who will not roar with laughter at this little world of medical flies—foul sanitary moths, as Rabelais might proclaim.

Louisiana State Medical Society Notes.

In Charge of Dr. P. L. Thibaut, Secretary, 141 Elk Place.

NEXT MEETING, NEW ORLEANS, MAY 8, 9, 10, 1906.

OFFICERS—President, Dr. C. J. Ducote, Cottonport; 1st Vice-President, Dr. J. F. Oechsner, New Orleans; 2nd Vice-President, Dr J. J. Ayo, Bowie; 3d Vice-President, Dr. D. R. Sartor, Alto; Secretary, Dr. P. L. Thibaut, 141 Elk Place, New Orleans; Treasurer, Dr. M. H. McGuire, 1114 Webster Street, New Orleans.

COUNCILLORS—Chairman, Dr. E. J. Graner, 2nd Cong. Dist., 1633 First Street, New Orleans; Secretary, Dr. H. L. Ducrocq, 3d Cong. Dist., Lafourche Crossing; Dr. P. E. Archinard, 1st Cong. Dist., New Orleans; Dr. N. K. Vance, 4th Cong. Dist,, Shreveport; Dr. R. F. Harrell, 5th Cong. Dist., Ruston; Dr. C. M. Sitman, 6th Cong. Dist., Greensburg; Dr. C. A. Gardiner, 7th Cong. Dist., Sunset.

ADDITIONS TO PROGRAM.

Since the publication of the program in last issue of the JOURNAL the following Chairmen of Sections have sent in their titles:

Medical Jurisprudence.—Chairman, Dr. Philip Asher, New Orleans.

Subject: "Medical Jurisprudence from the Pharmaco-Medical Standpoint."—To open discussion: Drs. E. S. Matthews, Bunkie, and Allan Eustis, New Orleans.

Oral Surgery.—Chairman, Dr. Samuel Logan, New Orleans.

Subject: "Asepsis in Mouth Operations."—To open discussion: Dr. Emil Regard, Mansura.

Obstetrics and Gynecology.—Chairman, Dr. Paul Michinard, New Orleans.

Subject: "Menorrhagia and the Microscope."—To open discussion: Dr. L. Perrilliat, New Orleans, and T. L. Mills, Jr., Baton Rouge.

For titles of the other sections and names of openers of discussions, see last month's JOURNAL.

The following titles of papers have been received since last publication:

"Raynaud's Disease: Report of a Case, with Cure," by Dr. A. E. Fossier, New Orleans.

"The Anomalies of Typhoid Fever," by Dr. Joseph Atkinson, Arcadia.

"Treatment of a Case of Post-Typhoid Sepsis (Delafield's Second Form), with Quick Recovery," by Dr. E. M. Dupaquier, New Orleans.

"How to Meet the Symptoms Tympany and Colitis in Typhoid Fever," by Dr. E. M. Dupaquier, New Orleans.

"Scarlet Fever, with Clinical Report of a Case," by Dr. R. W. Faulk, Monroe.

"A Case of Primary Carcinoma of the Bile-Ducts, with Autopsy," by Dr. B. O. LeBlanc, St. Gabriel.

"A Brief Review of Some Important Points Regarding Tuberculosis," by Dr. W. J. Durel, Covington, La.

"Experiences During the Yellow Fever Epidemic of 1905," by Dr. Henry Dickson Bruns, New Orleans.

"Multiple Malarial Infection: Report of a Case of Quadruplicate Tertian Malaria," by Dr. F. H. Watson, New Orleans.

"Some of the Causes of Insanity," by Dr. E. M. Hummel, Jackson, La. (Changed from "The Cause of Insanity," as published in last issue of JOURNAL.)

"Nervous Dyspepsia and Its Treatment," by Dr. Sidney K. Simon, New Orleans.

"Report of Two Unusual Cases of Urethral Lesions," by Dr. Carroll W. Allen, New Orleans.

"Isolation Hospitals," by Dr. Hamilton P. Jones, New Orleans.

"Some Recent Observations on the Life-Habits of Stegomyiæ," by Mr. J. C. Smith, New Orleans.

"Co-operation Among the Southern States in the Prevention and Control of Epidemics," by Dr. W. H. Sanders, Montgomery, Ala.

"Spina Bifida: Report of a Case," by Dr. E. D. Fenner, New Orleans.

"The Ambulatory Treatment of Fractures of the Femur," by Dr. J. M. Batchelor, New Orleans.

"Treatment of Chronic Ulcer of the Leg," by Dr. A. Jacoby, New Orleans.

"Lacerations of the Posterior Vaginal Wall: The Importance of Their Diagnosis and Repair," by Dr. E. Denegre Martin, New Orleans.

"Differential Diagnosis Between Yellow Fever and Dengue," by Dr. G. Farrar Patton, New Orleans.

"A Suggestion as to the Etiological Factor of Yellow Fever, from the General Symptomatology and Particular Behavior of the Blood-Cells," by Dr. H. L. Ducrocq, Lafayette, La.

"Diagnosis and Medical Treatment of Gall-Stones," by Dr. A. B. Nelson, Arcadia.

"Faulty Metabolism in Young Children: Its Causes and Correction," by Dr. T. S. Dabney, New Orleans.

"Cyst of the Round Ligament Simulating Inguinal Hernia," by Dr. E. T. Newell, St. Joseph, La.

"The Operative Surgery of the Spine and Cord," by Dr. Warren Stone Bickham, New York.

"The Abortion of Pneumonia," by Dr. V. Lehmann, Hahnville.

"Quarantine Regulations Affording the Greatest Protection with the Slightest Hardship," by Dr. M. J. Magruder, New Orleans.

"Some of the Difficulties in the Diagnosis of Yellow Fever," by Dr. L. Sexton, New Orleans.

"Exstrophy of the Bladder: Report of a Case, with Remarks on Its Operative Treatment," by Dr. F. W. Parham, New Orleans.

REORGANIZATION OF ACADIA PARISH MEDICAL SOCIETY.

The physicians of Acadia Parish met March 22, 1906, at Rayne, and reorganized the Acadia Parish Medical Society, with the following officers: President, Dr. L. B. Arceneaux, Church Point; Vice-President, Dr. M. L. Hoffpauir, Crowley; Secretary-Treasurer, Dr. J. D. Hunter, Rayne. Other charter members are: Drs. R. C. Webb and J. P. Mauboules, Rayne; H. C. Webb and Thomas H. Toler, Crowley; B. E. Clark, Branch; L. A. Clark, Iota; R. E. Cunningham, Castille; Frank Savoy, Church Point.

IMPORTANT NOTICE TO OUT-OF-TOWN MEMBERS.

The railroads having agreed upon a rate of one fare for the round trip, it will not be necessary to get a receipt from the ticket agent. All you have to do is to pay for a round trip ticket, take the train and come to New Orleans to have a good time. Tickets are good from May 7 to 12, inclusive.

TO DELINQUENTS.

The attention of members who have not yet paid their dues is called to Chapter I, Section 4, of the By-Laws of the Society, which provides that a member who has failed to pay his dues shall not take part in any of the proceedings of the Society.

RULES FOR ORIGINAL PAPERS.

By-Laws, Chapter III, Sections 4 and 5, provide as follows:

"Sec. 4. No address or paper before the Society, except those of the President or Orator, shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes nor more than once on any subject, except all others desiring so to do shall have spoken.

"Sec. 5. All papers read before the Society shall be its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published."

AN OPEN LETTER TO MEMBERS.

DEAR DOCTOR:

It is proposed to make the next meeting of the Louisiana State Medical Society, to be held in New Orleans, May 8, 9 and 10, one of the most interesting in the history of the organization. Your officers and committees are exerting themselves to this end; will you not assist? While interesting features may be arranged, we fully realize that the ultimate success of the meeting will depend upon the interest manifested by the individual member.

All that we really ask is that you display sufficient interest to attend the meeting, and we feel justified in promising that you will go home satisfied with the result.

Dr. James Carroll, a distinguished officer of the War Department, has, upon urgent request, been specially assigned here for this session, and will read a paper on some subject bearing on the transmission of yellow fever by stegomyiæ, and as Dr. Carroll was one of the original investigators, a member of the commission appointed by the United States Government to conduct the experiments in Havana which definitely settled this question, every member of the Society should avail himself of this opportunity to hear him.

Dr. Warren Stone Bickham, formerly of New Orleans, but now a distinguished surgeon of New York, author of one of the most comprehensive works on surgery now in use by the profession, will read on the Surgery of the Spinal Cord, opening a symposium on this subject, as will Dr. Carroll's paper on yellow fever, both of which will be joined in by prominent men specially prepared for the discussion of these subjects.

Dr. J. H. White, of the United States Public Health and Marine Hospital, so well and favorably known through the victory achieved in stamping out yellow fever in New Orleans during the summer of 1905, as to need no introduction to any one connected with this Society, will read a paper full of interest to us all.

The Annual Orator this year will be Mr. Henry P. Dart, a distinguished member of the Bar of New Orleans, who will take for his subject the relation of National and State Quarantines, giving to us the carefully prepared and well digested views and opinions of a man than whom there is probably no one in this country better qualified to speak.

On each day of the session there will be some social feature, in order to vary the business routine and provide opportunities for the renewal of old friendships and cultivation of a warmer, more fraternal feeling in the profession. These will consist of something in the form of a buffet luncheon on the first and second days and the usual annual banquet on the evening of the last day, when all restraint will be thrown off and troubles drowned in bubbles.

Now, don't feel that your professional duties demand all of your time; remember, you owe something to yourself and profession of which you are a member, so for the time put aside cares and come to the meeting.

The railroads, too, are affording us extra inducements this year; instead of the usual rate of one and a third fares for the round trip, they will sell on May 7 and 8 round trip tickets for one fare plus 25 cents, good to return until the 12th. No receipts or certificates are required; you merely buy a round trip ticket to New Orleans, paying therefor 25 cents in addition to price of fare from your town to this city, exacting no receipt from the agent, except in the event of a refusal to sell ticket as stated, in which case a receipt should be demanded and upon arrival in the city turned over to the secretary.

Cordially yours,

(Signed.) M. J. MAGRUDER, M. D.,
Chairman Committee on Arrangement.

Parish Society Notes.

THE VERNON PARISH MEDICAL SOCIETY held its annual meeting in Leesville Wednesday, April 4. It was largely attended and was one of the most enthusiastic meetings we have ever had. The Leesville members entertained the visiting brethren with a sumptuous banquet, which was sandwiched in between the business and scientific portions of our meeting. This added zest to our zeal, joy to our meal, and made us all feel that to feed a man's face was four jacks and an ace against a poor hand..

We had expected on this occasion to have with us Dr. C. A. Gardiner, Councillor of the Seventh District, but pressure of business at the last moment prevented his coming.

Several important resolutions were passed upon. The resolution to amend our constitution on membership so as to include dentists as hononary members was favorably acted upon, but of course cannot be final for two meetings yet. I have already sent you a copy of that resolution.

I also inclose copies of three other resolutions which met with unanimous approval.

We had a fine scientific programme which all entered into heartily.

The following officers were elected: President, Dr. J. D. Tuten, of Barham; Vice-President, Dr. M. Monk, of Leesville; Secretary-Treasurer, Dr. F. W. Dortch, of De Ridder.

Meetings are held every three months.

Resolutions adopted:

A resolution against the patent medicine scourge in the United States to the effect that the Vernon Medical Society as an organization shall take up the cudgel against it:

First—By endorsing the proposed bill which appears in the *Ladies' Home Journal* of February, 1906.

Second—By having our secretary send a copy of this bill to our Senator and Representatives and urge them in the name of the society and for the sake of their own safety and that of their loved ones and their constituency to leave no stone unturned to pass it.

Third—By using the funds in our treasury to send a man at the proper time to Baton Rouge to personally urge our Representatives and Senator to vote for this bill.

Fourth—By urging the State Society to make similar and much stronger efforts.

Proposed by Dr. F. W. Dortch.

Unanimously carried at meeting of April 4, 1906.

A resolution to amend the By-Laws of the Vernon Parish Medical Society in behalf of sociability, said amendment to be termed "Amendment No. 1," and to read as follows:

Amendment No. 1—Section 1. This society shall hold an annual banquet on the evening of the day upon which it holds its annual meeting.

Sec. 2. If there are not sufficient funds in the treasury to defray the expenses of said banquet, the society may make a pro rata assessment sufficient to cover the deficit.

Sec. 3. Upon this occasion the outgoing president shall deliver an address upon some suitable subject.

Sec. 4. The society shall also have a banquet orator, to be selected by the president in conjunction with the Program Committee and at least six months before the annual meeting, and that it shall not be necessary that this committee confine their selection to the membership of this society, nor to the jurisdiction of this society.

Proposed by Dr. F. W. Dortch.

Unanimously carried at meeting of April 4, 1906.

A resolution protesting against the efforts of life insurance companies to reduce the fees for medical examinations, and to read as follows:

Resolved, That the Vernon Parish Medical Society commend the action of the St. James Parish Medical Society, and that we enter with them in their protest against insurance companies reducing the minimum fee for a medical examination below $5.

Also that with them we demand that the Louisiana State Medical

Society take some action upon this question at its next meeting, and that it be brought before the American Medical Association in proper form.

Proposed by Dr. F. W. Dortch.

Unanimously carried at meeting of April 4, 1906.

BIENVILLE PARISH MEDICAL SOCIETY met at Gibsland, La., April 10, 1906. Meeting called to order by President Dr. J. Atkinson. Drs. Atkinson, Nelson, Hamner, T. H. Pennington, Thornhill, Colvin, A. J. Pennington and Smith present.

After the reading and correction of the minutes of the previous meeting, there being no reports or business to come before the society, the regular program was taken up, beginning with an able paper by Dr. Nelson on "Diagnosis and Treatment of Gall Stones." Discussion opened by Dr. T. H. Pennington.

The society then adjourned to meet at 1:30 p. m.

Afternoon session called to order by the president.

The program was resumed by Dr. Colvin, with an interesting paper on "Influenza." Discussion led by Dr. Thornhill.

Dr. A. J. Pennington, in lieu of his paper on "Scarlet Fever," which was continued to next meeting, presented in detail a case of labor with complications, which was given a lengthy discussion.

This was followed by the examination of patient, and discussion of a case of epilepsy, presented by Dr. Hamner.

Dr. Nelson then presented the following resolution, seconded by Dr. Thornhill, and unanimously adopted by the society:

Whereas, We, the members of the Bienville Parish Medical Society, deem the reduction of the rate of fees from five dollars to three dollars for examinations by the old line life insurance companies an injustice to the medical profession:

Therefore be it resolved, That the members of this society cease to examine for these companies until they have raised the fee to five dollars; and that any member of this society violating this resolution shall be subject to expulsion from the society by a two-thirds vote of its members.

Motion was then carried that a synopsis of the minutes of this meeting be sent the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL for publication in next issue. The committee on program reported the following program for next meeting, July 10, 1906:

"Scarlet Fever," Dr. A. J. Pennington.

"Typhoid Fever," Dr. Wilson.

"Electro Therapeutics," Dr. T. H. Pennington.

"Some of the More Common Diseases of Children Met with by a Medical Practitioner."

THE FRANKLIN PARISH MEDICAL SOCIETY met at Winnsboro, La., April 10, 1906, in regular session. The following members were present: Drs. L. M. Griffin, President; C. L. Ramage, Vice-President; H. B. Womble, Secretary and Treasurer; C. L. Guice, J. M. Denson, N. H. Berry, J. A. McNair, J. G. Gulledge, R. L. May, J. W. Poindexter.

Dr. W. A. Mecom of Holly Grove was received into membership.

The discussion on "Gastro-Intestinal Diseases of Infancy and Childhood" was opened by Dr. Guice in an admirable manner, and participated in by all the members present.

The State Board of Medical Examiners were notified that three men are practicing illegally in this parish.

After the meeting a banquet was served at the Elam Hotel, attended by the physicians' families.

MEETING OF BI-PARISH MEDICAL SOCIETY (Red River and Natchitoches).—At a regular meeting of the Bi-Parish Medical Society, held Wednesday, April 4, 1906, at Coushatta, La., the following answered to roll call: Drs. C. E. Edgerton, W. T. Williams, W. A. Boylston, E. O. Edgerton, O. C. Teagle and E. W. Breazeale. Rev. Mr. Sheppard delivered prayer.

Reading of minutes of last meeting dispensed with.

Report of Cases—Dr. C. E. Edgerton, on *Hysteria;* Dr. W. T. Williams, *Two Cases of Catalepsy.*

The following resolutions were adopted:

By C. E. Edgerton:

That Natchitoches and Coushatta be the permanent meeting places of this society; to meet at above places alternately.

By Dr. Edgerton:

Whereas, There will be a bill introduced in the Legislature at its coming session that has been approved by the State Medical Society, for the regulation of the practice of medicine in the State of Louisiana; and, *Whereas,* It is the desire of the Bi-Parish Medical Society, composed of the Parishes of Red River and Natchitoches, that said bill become a law at the present session of the State Legislature of Louisiana:

Therefore, be it resolved, By the Bi-Parish Medical Society, composed of the Parishes of Red River and Natchitoches, in regular session convened at Coushatta, Red River Parish, La., on this, the 4th day of April, 1906, that the Representatives and Senators representing the Parishes of Red River and Natchitoches in the General Assembly of the State of Louisiana be earnestly requested by this society to vote for and actively support said bill as approved by the State Medical Society.

Be it further resolved, That the secretary of this society be requested by the society to furnish a copy of these resolutions to each Representative and Senator from the Parishes of Red River and Natchitoches in the General Assembly, and that these resolutions be published in the JOURNAL.

By W. T. Williams:

We hereby protest against the practice of certain life insurance companies in paying less than $5 for any medical examination. We see no reason why a smaller fee should be paid for one examination than for another, since the work is always the same.

We have noted with surprise that, while the examination fees were being cut down on the plea of economy, all other expenses were enormously increased, although the examining physician is the most important employee of any company, as its success or failure will depend on the quality of his work.

We demand that the Louisiana State Medical Society take some action on this question at its next meeting, and that it be brought before the American Medical Association in proper form.

By Dr. Edgerton:

That all dues must be paid before the meeting of the State Medical Society in May.

The following officers were elected: E. O. Edgerton, President; C. E. Edgerton, First Vice-President; O. C. Teagle, Second Vice-President; E. W. Breazeale, Secretary and Treasurer.

The president appointed the following members to read and discuss papers at our next meeting:

Surgery—R. L. Jones; for the discussion, J. A. Hendrick and J. L. Page.

Heart Diseases—E. W. Breazeale; for the discussion, W. W. Tur and O. C. Teagle.

Practice—P. E. Waddell; discussion by J. T. Keator and S. H. Scruggs.

Meeting adjourned to convene at Natchitoches, La., on Wednesday, Dec. 5, 1906.

(Signed) E. W. BREAZEALE,
Secretary and Treasurer.

Morehouse Medical Society.

Died.—Dr. A. W. Jones, at one time vice-president of the State Medical Society, died on March 16, 1906, at Plantersville, La., after a short illness.

The distinction which Dr. Jones had occupied in his own community and in that of the State occasioned a lengthy and expressive memorial from the Morehouse Medical Society, of which he was an early member and president for several years.

Dr. Jones was born at White Hall plantation, Morehouse Parish, La., on May 31, 1856, and graduated from the Medical Department of Tulane University in 1883. He began practice in North Louisiana, and the town in which he located has adopted his name.

Dr. Jones was an earnest student, frequently leaving his active practice for post-graduate investigation and study, and his opinion was valued by his contemporaries, who frequently availed themselves of his ability. He was identified with the Board of Health of his parish; was a member of the Police Jury, and his life testified to his citizenship. He was reserved and modest, thoughtful and dutiful, a devoted husband and father, a citizen of the pure Southern type and a man who made life simple and lofty and glorious for himself and those about him.

(Material for this notice supplied by Dr. Sidney L. Williams, of Oak Ridge, La., and Dr. O. M. Patterson, of Bastrop, La., secretary of the Morehouse Parish Medical Society.)

The Avoyelles Parish Medical Society met in regular quarterly session at Marksville on April 5. Twenty-five members were present. The application of Dr. E. A. Porch of Hessemer was voted on, and he was eletced to membership.

The morning session was for the profession, and a paper on the "Third Stage of Labor" was read by Dr. E. S. Matthews of Bunkie. This paper proved a good topic for discussion, which was engaged in by Drs. Regard, C. J. Ducote, Morgan, Drouin, Fox and Jeansonne. The paper will appear in the JOURNAL. A clinical case of gunshot wound of the chest with empyema was demonstrated by Dr. R. G. Ducote of Bordelonville.

Mansura was selected as the next meeting place, and the subject of abortion and its treatment will be discussed. Dr. Thomas A. Roy is essayist. Dr. E. Regard will open the discussion. The meeting then adjourned to the People's Restaurant, where a sumptuous dinner was served. A feature of this dinner was the presence of the wives and sweethearts of the members. This special feature will hereafter be observed once every year. Toasts were offered to "The Ladies," by Dr. G. R. Fox; "The Avoyelles Parish Medical Society," by Dr. Emil Regard; "The State Medical Society," by Dr. C. J. Ducote. Dr. W. F. Couvillion, the president, acted as toastmaster.

The afternoon session was held as an open meeting, and a large audience greeted Dr. C. J. Ducote when he arose to read his paper on "Yellow Fever—Etiology, Propagation and Prevention." It was then discussed by several members present and the essayist was voted the thanks of all present for his splendidly prepared paper.

THE ST. LANDRY PARISH MEDICAL SOCIETY met in Opelousas on March 20. At that meeting the officers were elected for the following year. Dr. C. A. Gardiner was elected president. The society elected a vice-president for each police jury ward in the parish, as follows: First, Dr. I. E. Shute, Opelousas; Second, Dr. T. T. Tarlton, Grand Coteau; Third, Dr. G. Richard, Leonville; Fourth, G. H. Hawkins, Palmetto; Fifth, L. Lazaro, Washington; Sixth, not filled; Seventh, Dr. J. C. Vidrine, Ville Plate; Eighth, Dr. Armand Lafleur, near Opelousas.

Dr. R. M. Littell was elected secretary and Dr. W. R. Boudreau treasurer.

Three interesting papers were read before the meeting.

Medical News Items.

The United States Civil Service Commission Announces an examination on June 6 and 7, 1906, for the position of Medical Interne at the Government Hospital for the Insane in Washington and for vacancies in any branch of the same service as they may occur. The appointment is for one year, and the department reserves the right to continue or terminate this at the end of a year, or to promote the appointee at the expiration of this service. Applicants should at once apply to the U. S. Civil Service Commission at Washington for the form of application. Examinations will be held under special commissioners, those in Louisiana to be at Baton Rouge, New Orleans and Shreveport; in Texas, at Austin, El Paso, Ft. Worth, Houston, San Antonio and Waco; in Mississippi, at Greenville, Meridian and Vicksburg, and in Alabama, at Birmingham, Mobile and Montgomery.

Combination of Indiana Medical Schools.—The Indiana medical schools have united to form a combination under the Medical Department of Purdue University located in Indianapolis. The Deans of the Medical College of Indiana, the Central College of Physicians and Surgeons, and the Fort Wayne School of Medicine have issued a circular explaining the motive for this change, and declaring it the result of the concert of action, the idea being to concentrate medical teaching at an institution located in a city of sufficient size to offer the necessary advantages and opportunities required in a modern school. This result has been obtained only after several years of discussion and endeavor, but the result justifies the labor expended. The spirit is essentially one aimed at the radical improvement of teaching facilites for those aiming at a medical career.

Fee Bill Issued by the St. Landry Society.—The St. Landry Medical Society has issued a printed fee bill, adopted and circulated among its membership, covering regular work in general practice, midwifery and surgery. This will prove useful to those interested, particularly as it allows a harmonious relation in the profession, and acts as a guide to intending patients as to the probable expense attached to their medical care.

Donation by Andrew Carnegie.—A gift of $10,000 from Andrew Carnegie to the College of Physicians and Surgeons of Atlanta, Ga., was announced at the annual commencement exercises of the college. An effort is being made by the trustees of the college to raise $100,000 to erect new buildings for the institution, and Mr. Carnegie's offer is to give the last $10,000 of this sum. Another gift of $10,000 was made also by Dr. A. Calhoun of Atlanta.

Japan and China.—An opportunity of seeing Japan and China is open to all interested, who will address Dr. Alexander J. Stone, University of Minnesota, St. Paul, Minn. Leaving St. Paul July 21, the excursion concludes at the same place about October 9.

The Louisiana State Board of Medical Examiners will hold its semi-annual examination in this city on May 3 and 4, at 9 a. m., at the Tulane Medical College, Canal street.

Illegal Use of a Name.—The Branch Appellate Court of Chicago has decided that the so-called Christian Hospital must pay a fine of $250 for the use of the name of Dr. John B. Murphy, of Chicago, without permission. Proceedings were brought by Dr. Murphy, who secured an injunction restraining the defendants from using his name. Sometime ago Dr. Murphy received a letter from the president of the hospital which informed him that he had been elected president of the medical and surgical staff of the above named institution. As Dr. Murphy had never heard of the institution he refused to have anything to do with it.

The Medical Society of the County of New York celebrated its hundreth anniversary, on the 4th of April, with a dinner at the Hotel Astor.

The Forty-First Annual Address to the graduating class at Mobile, Alabama, on April 9th, was made by Dr. J. H. Penniman, of Philadelphia, Dean of the University of Pennsylvania.

The Mississippi State Medical Association closed a successful meeting on April 20. The following officers were elected for the ensuing year: President, W. W. Crawford, Hattiesburg; Vice-President, J. W. Young, Grenada; E. A. Cheek, Arcola; J. R. Tackett, Meridian. Councillors—First district, E. H. Martion of Clarksdale; Fifth district, W. D. Smith, Franklin; Sixth district,

M. H. Bell, Meridian. Delegates to American Medical Association—John Darrington, of Yazoo City; W. H. Harrison, of Luteville. Gulfport was selected as the next place of meeting, which will be held on the second Wednesday in April, 1907.

Personals: Mr. J. E. Ellis, formerly with Philadelphia hospitals, has been made Superintendent of the Touro Infirmary. Miss Miriam Scharff will have charge of the Training School for Nurses.

Dr. D. D. Mims has been elected president of the Crowley Board of Health.

Dr. Heber Jones of Memphis, Tennessee, was elected president of the Tennessee State Board of Health to succeed the late Dr. W. J. McMurray. Dr. Jones is well known throughout the South, and played a very prominent part in the recent quarantine against the South during the New Orleans epidemic.

Dr. Charles Warrenne Allen has been appointed the delegate of the American Dermatological Association to the Fifteenth International Congress t obe held at Lisbon, April 19 to 26.

Dr. J. K. Sheppard has moved from Elm Grove, La., to Sligo.

Dr. R. K. Hackett has returned from Dallas, Texas, where he has been for several weeks, and will remain in New Orleans to practice.

Dr. G. E. Cannon, of Jonesboro, La., has changed location, and is now at Alexandria.

Dr. L. E. Litton has moved from Cheneyville, La., to Tioga to practice.

Married: Dr. J. Hall LeBlanc, of Whitecastle, La., was married to Miss Anna Dyer, of Napoleonville, on April 2d.

Died: Dr. Solomon C. Martin, formerly of New Orleans, died at his home in St. Louis on March 28. The doctor had been practicing medicine for over forty years.

Dr. W. H. Barr died suddenly at Starkville, Miss. Dr. Barr was the physician in charge of the Agricultural and Mechanical College of Starkville.

On Monday, April 9, Mathilde Marie Levert, wife of Dr. F. J. Kearny, of Plaquemine.

The death of Dr. C. K. Parker occurred at Bonita on April 10 at the residence of his brother- in-law. Dr. Parker graduated from Tulane in 1895.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Progressive Medicine, edited by HOBART AMORY HARE, M. D., assisted by H. R. M. LANDIS, M. D. Lea Brothers & Co., Philadelphia and New York, December, 1905.

This quarterly digest grows more valuable with each issue. We are able to pick out only a small part of the good meat of the nut, for in a review of this kind we must necessarily be brief.

In Schutz's study of 100 cases of carcinoma of the esophagus we read that the diagnosis was confirmed in every case by the subsequent course of the disease. The seat of the cancer was in the upper third in 10 per cent.; in the middle third in 33 per cent.; and in the lower third in 57 per cent. In our own experience we have also found the greater number to be in the lower third. The apparatus devised by Strauss to estimate esophageal dilatation and to differentiate simple dilatation from diverticula is illustrated. The difficulty of the diagnosis of the gastric and abdominal crisis in tabes is emphasized, as the crisis may appear before any of the classical symptoms of tabes. The serum diagnosis of carcinoma of the stomach is as yet far from being satisfactorily proved.

As to the importance of detecting occult blood in the feces, we read: "Occult bleeding has in general the same clinical significance as visible hemorrhage, except that its recognition is a much more delicate means of diagnosis because the quantity of blood present is so small. Practically, however, the presence of occult blood is of decided diagnostic value, chiefly in the detection of gastric or duodenal ulcer of gastro-intestinal cancer, because it occurs with considerably more regularity and frequency in these two affections than in any other condition of the alimentary canal."

The chapter on the clinical examination of the stools shows the importance of the subject to practical medicine.

Under the heading of "Surgical Shock," Dr. Joseph C. Bloodgood emphasizes the necessity for the better training of future surgeons in the department of surgical physiology. He thinks that facts of great value are often lost to the practical surgeon by lack of training in this direction. Further, he says of Crile's work that while it lacks the precision and absolute accuracy which should characterize all physiological investigations, and while perhaps his conclusions are based on insufficient data, still some of Crile's work has proved to be of great practical value to surgeons.

Under the treatment of shock, we read: "Although in laboratory experiments salt infusions are somewhat disappointing in their effect, they are not harmful, and in practical experience there seems to me to be no question as to their value. Whether the addition of coffee to the usual rectal salt enemata so frequently employed is of value I am not prepared to say. In patients who are somewhat shocked after long operations with general narcosis, we observe that they recover more rapidly and have less postoperative discomforts if the amount of urine eliminated is over 1200 c.c. per diem. The continuation of subcutaneous salt infusions in critical cases and rectal salt enemata in all cases undoubtedly increases the amount of urine. Theoretically this should be associated with a more rapid elimination of the poisonous effects of the anesthetic and perhaps the blood ferments in the wound. I have been impressed that in the cases in which coffee has been added to the rectal enemata during the first twenty-four or forty-eight hours the amount of urine is greater than when salt is used alone. Coffee undoubtedly is a diuretic; it is also a cardiac stimulant. I can find no experimental work with coffee or its alkaloid, caffein, along the lines similar to those made with strychnin and digitalis. If the effect of coffee is similar to the other cardiac stimulants it should not be used in shock. Intravenous and subcutaneous salt infusion and salt solution enemata are methods of treatment which are not employed as frequently as they should be."

Under the heading of "Blood Pressure," we quote: "At the present time my own experience is not sufficient to estimate the practical value of blood-pressure records in surgical cases and during operations. I am impressed, however, that it is a very important field for further investigation."

Under the heading "Spinal Anesthesia" mention is made of Bier's paper before the last German Surgical Congress in April, 1905. In this paper he advocates the use of stovain, a preparation by a French chemist for cocain. He also advocates the addition of adrenalin or like preparations to these injections. Speaking of general anesthesia Wohlgenuth says that the anesthetist must be prepared and trained to keep the patient under partial or deep narcosis as indicated by the nature of the operative manipulations.

In writing of general anesthesia produced by ether given per rectum, Bloodgood says: "I witnessed this method for the first time in Boston, both in the Massachusetts General and the City Hospitals. Demonstration was made before the Clinical Society of Surgeons which met there in April, 1905. I was impressed that it had a distinct field as the method of narcosis in thoracic surgery, especially when the Sauerbruch's pneumatic chamber is employed."

The busy practitioner unable to read many journals will find *Progressive Medicine* his salvation. STORCK.

A Text-Book of Practical Therapeutics with special reference to the application of remedial measures to disease and their employment upon a rational basis, by HOBART AMORY HARE, M. D., B. Sc. Lea Brothers & Co., Philadelphia and New York, 1905.

That this worthy book has reached its eleventh edition in fifteen years proves that it is appreciated by those for whom it was intended, namely: the physicians and undergraduate students of medicine.

It has been the aim of the author, as set forth in Part IX on applied therapeutics, not to provide a rigid system for treating disease but rather to bring together the best remedies and to show how and why they are given.

A large number of alterations made necessary by the appearance of the new United States pharmacopœia have been made. The addition of preparations of the British pharmacopœia enhances the value of this work.

The articles by Drs. G. E. de Schweinitz, Edward Martin and Barton C. Hirst may be read with profit by all students of therapeutics.

We think it wise that the author has omitted the subject of medicinal electricity from this work, for, as the author well says, "electrical therapeutics has outgrown any work save one devoted to that subject alone."

STORCK.

Pharmacology and Therapeutics, by REYNOLD WEBB WILCOX, M. A., M. D. LL. D. Sixth edition. P. Blakiston's Son & Co., Philadelphia, 1905.

In revising his Materia Medica and Therapeutics, Dr. Wilcox has found it necessary from the growth of new material to divide the work into two volumes. The first, which we reviewed a short time ago, is styled Materia Medica and Pharmacy, full attention being given to pharmaceutical processes and such other matter as is appropriate to a work of its kind.

In this, its companion volume, the subject of pharmacology and therapeutics is well and ably handled, the author being thoroughly competent through his vast experience to edit a creditable book on this important branch of medicine. The classification adopted in the present work is based on the particular physiological systems upon which the various drugs or other agents principally act.

The work presents the views of the highest authorities in pharmacology and therapeutics. It is thoroughly modern in every particular, and reflects credit on its author. STORCK.

Text-Book of Medical and Pharmaceutical Chemistry by ELIAS H. BARTLEY, B. S., M. D., Ph. G. Sixth edition. P. Blakiston's Son & Co., Philadelphia, 1905.

This work of Dr. Bartley is well known to students of medical and pharmaceutical chemistry, and is a reliable guide to things chemical of interest to students in this branch. A considerable number of analytical processes included in former editions have been dismissed, as they did not properly belong in a book not intended as a laboratory manual. Much new matter has been added, considerable of it being made necessary by the recent revisions of the pharmacopœias of the United States and Great Britain. The author makes mention of his indebtedness to the works of Hoppe-Seyler and Battaze. As in former editions, cuts from Landor's and Sterling's Physiology are used, for which due credit is given.

STORCK.

A Laboratory Manual of Physiological Chemistry, by ELBERT W. ROCKWOOD, M. D., Ph. D. F. A. Davis Co., publishers, Philadelphia, 1905.

The first edition of this manual was issued in 1899, and was met with favor by students in this department. This, the second edition, has been brought about of our present day knowledge of this now important branch of medical education. The present volume is enriched by suggestions from Dr. D. W. Fetterolf, of the University of Pennsylvania, and Dr. Paul Bartsch, of Howard University. In the main, the book is representative of the course in physiological chemistry given in the University of Iowa, where Professor Rockwood is at the head of the department of chemistry. What will appeal most to the student is the fact that a great number of the experiments have been so arranged as to require but a small stock of apparatus, and such reagents as are readily obtainable.

STORCK.

A Compound of Medical Chemistry Inorganic and Organic, Including Urinary Analysis, by HENRY LEFFMANN, A. M., M. D., P. Blakiston's Son & C., Philadelphia, 1905.

In this work the student of medical chemistry will find a valuable aid in acquiring a knowledge of this branch of learning.

Dr. Leffmann has the faculty of selecting those subjects upon which the student should be informed and upon which he is most likely to be examined.

We quite agree with the author that "Medical Chemistry" is as appropriate a title as "Analytical Chemistry," "Physical Chemistry" or "Organic Chemistry." This compend has merit and will be found useful to the student of medical chemistry. STORCK.

Materia Medica for Nurses, by JOHN C. GROFF, Ph. G. Third edition. P. Blakiston's Son & Co., Philadelphia.

This small book contains all that is necessary for the nurse to know of materia medica, perhaps more than is ordinarily right for her to know. The text is clear and so comprehensive that it is just what it pretends to be, a useful guide, and as such it can be recommended. DYER.

Life and Matter—A Criticism of Prof. Haeckel's "Riddle of the Universe," by SIR OLIVER LODGE. G. P. Putnam's Sons, New York and London.

The direct interest of the medical man in all philosophy relating to the created being makes this book momentous, almost as corollary to that it tries to controvert, viz.: Haeckel's "Riddle of the Universe." It is essentially technical and covers the elemental problems of the unit life, relation of physical substance to intelligence and the speculation as to the origin of the animate essence of life. Suffice it to conclude with the thought that the effort of science to explain natural laws is still active and also still wanting. DYER.

A Compend of Diseases of the Skin, by JAY F. SCHAMBERG, A. B., M. D. Fourth edition. P. Blakiston's Son & Co., Philadelphia.

We have consistently reviewed this work as among the best of the smaller texts on the subject and we can only add that the author maintains the same standard of excellence in the revised edition before us.

DYER.

The Diseases of Infancy and Childhood, by HENRY KOPLIK, M. D. Second edition. Lea Bros., New York and Philadelphia.

The matter of prime notice in this most excellent text is the thoroughness of exhaustive detail which characterizes every section. The style is remarkably lucid, and no pains are spared in descriptive particulars. Of especial remark are the chapters on the Mother's Milk, the substitutes for this and the analysis of each method in vogue where the natural food is inadequate. The possible complications in the life history of the young infant are related and every care is exercised to demonstrate the exact procedure in every unusual condition. Deformities and anomalies receive proper consideration and the specific infectious diseases are handled academically; the article on measles is classic. No attention is given to anomalous vaccination results, which should have a place in so comprehensive a text. Considerable discussion of hereditary syphilis occurs, following in large part the teachings of Fournier. Each organ or group of organs is discussed from its semeiologic points and fulls details as to treatment and conduct are given. The work concludes with chapters on nerve disorders and diseases of the skin, the latter finding only cursory treatment and no attempt at analytic relation. In all some 850 pages are filled with a text which deserves general endorsement as a complete cyclopedic reference on pediatrics. DYER.

Christianity and Sex Problems, by HUGH NORTHCOTE, M. A. F. A. Davis Co., Philadelphia.

The second division of the title of this book is more correct than the first, for the correlation of Christianity with sex problems is only casual in the text. The work is really a protagonistic essay on morality, attacking apologetic methods sanctioned by modern society and condemned by Christian teachers and followers. Voluminous references are adduced and digested to further the worthy argument of the book. Celibacy and its merits, fornication and its evils, historic and actual, marriage, divorce, sex relations, legal and illegal, are each and all discussed broadly by the author-essayist, who spreads his sails for a millennial shore. DYER.

The Relation of Diseases of the Skin to Internal Disorders, by L. DUNCAN BULKLEY, A. M., M. D. Behman Co., New York and London.

Dr. Bulkley has published in series this division of his lectures at the New York Skin and Cancer Hospital, and presents a topic only touched upon in the usual text on dermatology. Himself a strong believer in the relations of internal organs to skin conditions, this book affords a personal expression of his views. The work before us hardly permits of a technical review, as the matter contained is mainly discursive and full of running comment on exact and theoretic cause and effect as found on the surface of the skin. The French school of dermatologists have long argued affiliation between internal disorders and local outbreaks, and it is in consonance with these ideas that the author finds both cause and reason for his efforts. DYER.

Publications Received.

P. Blakiston's Son & Co., Philadelphia, 1905.

The World's Anatomists, by Dr. G. W. H. Kemper.
A Manual and Atlas of Dissection, by Simon Menno Yutzy.

D. Appleton & Co., New York and London, 1906.

Diseases of the Nervous System, by Dr. Pierce Bailey.

G. P. Putnam's Sons, New York, 1906.

Sex and Character, by Otto Weininger, M. D.

Lea Bros. & Co., Philadelphia and New York, 1906.

Progressive Medicine, Vol. VIII, No. 1. (March 1, 1906.) Hare-Landis.

F. A. Davis Co., Philadelphia, 1906.

The Test Diet in Intestinal Diseases, by Adolph Schmidt and C. D. Aaron, M. D.

J. B. Lippincott Co., Philadelphia and London, 1906.

Medical Diseases of Infancy and Childhood, by Alfred C. Cotton, M. D.

Miscellaneous.

Hearings Before the Committee on Interstate and Foreign Commerce of the House of Representatives on House Bill 14,316 *to Further Protect the Public Health.* (Government Printing Office, Washington, D. C., 1906.)

Effects of Borax and Boric Acid on the Human System, by Dr. Oscar Leibreich. (J. & A. Churchill, London, 1906.)

The American Mosquito Extermination Society Year-Book for 1904-1905.

Report of the Department of Health of the Isthmian Canal Commission for the Month of January, 1906, by Col. W. C. Gorgas. (Government Printing Office, Washington, D. C., 1906.)

Case Teaching in Medicine, by Richard C. Cabot, M. D. (D. C. Heath & Co., Boston, 1906.)

Operative Treatment of Fractures, by Arbuthnot Lane, M. S., F. R. C. S. (Medical Publishing Co., Ltd., London, 1905.)

Annual Report of the Surgeon General of the Public Health and Marine Hospital Service of the United States for the Fiscal Year 1905. (Government Printing Office, Washington, D. C., 1906.)

American Society of Tropical Medicine, Vol. I.

An Act to Amend and Re-enact Medical Laws in Louisiana.

Medical and Surgical Report of St. Luke's Hospital for the Year Ending September 30, 1905.

Twenty-second Annual Report of the Kensington Hospital for Women for the Year Ending October 2, 1905.

The Bloodless Phlebotomist. (The Denver Chemical Manufacturing Co., 1906.)

Report of the Department of Health of the Isthmian Canal Commission for the Month of February, 1906, by Col. W. C. Gorgas. (Government Printing Office, Washington, D. C., 1906.)

Reprints.

Surdité Spontanée Ancienne, by Dr. Marcel Natier.

The Radical Operation for Inguinal Hernia, by Dr. Jos. Rilus Eastman.

(1) *Extrauterine Pregnancy;* (2) *The Treatment of Retrodisplacements of the Uterus;* (3) *Cancer of the Uterus,* by Dr. Chas. P. Noble.

A New and Rational Operation for the Correction of Prominent Ear, by J. T. McShane.

Criminal Abortion or Feticide, and the Prevention of Conception, by Dr. Henry C. Ghent.

Certain Fee Table Items That Injure the General Practitioner, by Dr. D. W. Cathell.

(1) *The Gynecologic Bladder;* (2) *Jaundice in the Newly-Born as Evidence of Umbilical Infection;* (3) *Nephropexy, Pro and Con,* by Dr. E. Gallant.

The Legislative Schemes of the American Medical Association. (Reprinted from The National Druggist, St. Louis, 1906.)

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR MARCH, 1906.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	4		4
Intermittent Fever (Malarial Cachexia)	1		1
Smallpox			
Measles			
Scarlet Fever	2		2
Whooping Cough			
Diphtheria and Croup	6		6
Influenza	8	8	16
Cholera Nostras			
Pyemia and Septicemia		1	1
Tuberculosis	41	43	84
Cancer	19	5	24
Rheumatism and Gout	1	1	2
Diabetes	2		2
Alcoholism			
Encephalitis and Meningitis	4	4	8
Locomotor Ataxia			
Congestion, Hemorrhage and Softening of Brain	19	8	27
Paralysis	4		4
Convulsions of Infants	2	3	5
Other Diseases of Infancy	18	5	23
Tetanus	4	5	9
Other Nervous Diseases	3	2	5
Heart Diseases	49	29	78
Bronchitis	6	3	9
Pneumonia and Broncho-Pneumonia	28	30	58
Other Respiratory Diseases	7	1	8
Ulcer of Stomach			
Other Diseases of the Stomach	2	1	3
Diarrhea, Dysentery and Enteritis	9	6	15
Hernia, Intestinal Obstruction	4	2	6
Cirrhosis of Liver	8	2	10
Other Diseases of the Liver	5		5
Simple Peritonitis			
Appendicitis	4		4
Bright's Disease	27	10	37
Other Genito-Urinary Diseases	4	3	7
Puerperal Diseases	2	4	6
Senile Debility	18	7	25
Suicide	4	1	5
Injuries	17	14	31
All Other Causes	12	15	27
TOTAL	344	213	557

Still-born Children—White, 23; colored, 18; total, 41.

Population of City (estimated)—White, 245,000; colored, 88,000; total, 333,000.

Death Rate per 1000 per annum for Month—White, 16.81; colored, 29.04; total, 20.07.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	30.06
Mean temperature	60.
Total precipitation	5.53 inches.

Prevailing direction of wind, south.

New Orleans Medical and Surgical Journal.

VOL. LVIII. JUNE, 1906. No. 12

Original Articles.

(No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the tenth day of the month preceding that in which they are expected to appear. A complimentary edition of one hundred reprints of his article will be furnished each contributor should he so desire. Covers for same, or any number of reprints, may be had at reasonable rates if a WRITTEN order for the same accompany the paper.)

THE ANNUAL REPORT OF 1906

To Edwin Boone Craighead, A. M., L. L. D., President of the Tulane University of Louisiana, at the Annual Commencement of the Medical Department, May 2, 1906, with an Address to the Graduates on

TWO YELLOW FEVER TOPICS.

By PROF. STANFORD E. CHAILLE, A. M., M. D., LL. D., Dean of the Medical Department, New Orleans, La.

Mr. President—This day will authorize 102 graduates in medicine, and seventeen masters of pharmacy, to commence their professional careers, and this addition to our alumni will increase their number, since the foundation of this college in 1834, to 3,922 doctors of medicine, and 371 masters of pharmacy.

The previous session was notable for the registration of 496 students, the greatest number that ever attended the Medical

Department, and, until July 22, 1905, it was confidently believed that the present session would be attended by not less than 525 students. It was then publicly announced that there had occurred an outbreak of yellow fever, the most threatening since 1858, when there were, in a population less than 170,000, nearly 5,000 deaths by yellow fever. Thereafter it was doubtful whether the attendance at the present session would amount to even 450, for the loss of students that followed the very fatal epidemics of 1867 and 1878 varied from about 18 to 30 per cent., while the loss by the insignificant outbreak of 1897 was about 9 per cent.

The total number of students registered this session was 487, a loss of less than two per cent. This unprecedented and gratifying result was unquestionably due chiefly to the demonstration, by September 1, that the vigorous warfare against mosquitoes, waged for the first time in New Orleans, was controlling the disease; and the demonstration, by October 20, that it was on the eve of extinction, prior to cold weather or frost, as had never before occurred.

This was one of the most triumphant demonstrations of the efficacy of the preventive measures adopted that has ever been secured; for never before has warfare on mosquitoes been prosecuted by and in behalf of so numerous a total and a non-immune population, and never so successfully after the establishment of so many foci of infection.

Most fortunate was it for New Orleans that the State and City Boards of Health and the volunteer ward organizations of public-spirited citizens united to co-operate cordially with the United States Public Health Service and that the public, which had for years ignored the familiar adage—"an ounce of prevention is worth a pound of cure"—did patriotically respond, when face to face with dire misfortune, to the imperative demand for the financial means indispensable to execute the requisite preventive measures. Never has the dictum of the wise Franklin—"God helps them who help themselves"—had better exemplification than in the fortunate results of these united efforts. This people will be criminal if they ever forget the lessons taught last summer—the efficacy of the preventive measures adopted, the necessity for their continuance and thorough execution and the impossibility of accomplishing this without adequate means.

In consequence of the successful efforts made the Medical Department suffered less than ever before when similarly endangered. Hence, profound and most grateful thanks are due, not only to the able leaders, Surgeon White, of the regulars, commander-in-chief, Dr. Warner, of the volunteers, and Mr. Janvier, replenisher of the purse that is as indispensable as the sword to all succcessful warfare; but also to the many sanitary officers and good citizens, who by their co-operation enabled these leaders to confer inestimable service on all our fellow-citizens, whose protection from disease is nearest to the professional duty of every member of the faculty and dearest to their hearts.

Under favorable conditions every one of our five classes of medical students would have been more numerous than the corresponding classes of the previous session. The evil influence of yellow fever reduced the classes of the first, second and third years, the best-paying classes, by about thirty students, while the two classes that pay the least, proportionately to their number, the class of candidates for graduation, and especially the post-graduate class, were more numerous. Hence, while our comparative loss in numbers was less than two per cent. the loss in fees has been greater. An illustration of the paradoxical fact that, although the medical profession and its colleges are dependent on disease for their livelihood, yet that disease tends to decrease their incomes; because, whenever the public health is impaired, the public gains less money and contributes less to the medical profession.

Notwithstanding the decrease in students and in revenue the educational progress of the Medical Department was still further developed by the addition of two more teachers and by increased and improved instruction in every one of the numerous studies that our students are now forced to prosecute. So confident is the faculty of the future progress of New Orleans and of the Medical Department that it has recommended for the next session increased outlay for additional educational improvements, and among these the lengthening of the session to twenty-nine weeks, three weeks longer than the sessions of most of the Southern colleges that our college is forced to compete with. Experience has amply proved that Southern medical students will most patronize the colleges that are least exacting in their requirements for graduation. Our college now exacts from its students higher fees than any other Southern college, and more time and more numerous and difficult examinations than most of these colleges. Hence, it would not be politic, notwithstanding our superior hospital and other educational advantages, to notably or suddenly augment our already comparatively greater requirements for graduation.

The most frequent and important questions every faculty has to decide demand thorough and conjoint consideration of three subjects: The educational ideals to be sought, the relative value of the different studies to be exacted of students, and the financial resources indispensable to execution. A noble enthusiasm for the highest educational ideals, while extremely attractive, has often proved an injury; because enthusiasm is prone to underrate the imperative necessity of adapting ideals to financial resources, and to overrate the probabilities of their adequate increase. For many years our Medical Department has been annually improved, if slowly, yet very surely. If the same policy be continued it will not be necessary to wait more than a few years, merely the time necessary to gain the full benefits of the Hutchinson fund, when far greater progress can be made than was ever before accomplished as quickly and as surely.

To realize the faculty's highest ideals of medical education would require an amount of money and of power that the end of this century will probably fail to supply. None the less, any notable addition to our present superior educational resources will so increase the attractiveness of this college to the most desirable students that, without dangerous conflict with good policy, greater requirements for graduation can be exacted; and thereby will accrue greater usefulness to the public and greater fame for the Medical Department and for the Tulane University of Louisiana.

Graduates of 1906.—This is my last opportunity to advise your class, one of the worthiest and surely the best instructed class ever graduated by the Medical Department. You have been graduated as doctors, that is, as competent teachers of your patients and of the public, not only in the cure but also in the prevention of disease. What should you teach in regard to the two following results of last year's yellow fever prevalence? One unfortunate result was the condemnation by the public of its chief sanitary officers, a usual result of any epidemic invasion that tends to injure the public; the second result was fortunate—unusual interest at the present time in the prevention of yellow fever.

Your attention is first solicited to some facts bearing on the question whether the public has usually practiced, in behalf of the very numerous sanitary officers it has fiercely denounced, the "square deal" that is so clamorously preached.

The public incessantly demands doctors skilled in curative medicine, but, in spite of the fact that preventive medicine is capable of conferring far greater benefits on the public than curative medicine, the demand for doctors in preventive medicine, that is, in hygiene or sanitation, is very insignificant. Hence, medical colleges teach chiefly curative medicine, and only the elementary facts and principles of preventive medicine; sufficient to supply graduates with more knowledge than the general public has, but insufficient to convert them into sanitary experts. The most enlightened countries now provide for graduates in medicine special courses in hygiene, with the requisite libraries, museums and laboratories, confer on those who complete the course a special degree and appoint no one a sanitary officer unless he has secured this degree.

Most of our American State and local Boards of Health, organized directly or indirectly by the people for the people, illustrate the popular belief that every doctor is a sanitary expert, especially if he be the relative or pet of a "boss" or a serviceable "striker" for some political machine. The results are that most of these boards are badly constituted and inefficiently administered, that the public, because of its own ignorance and negligence, fails to realize its *unreasonable* expectations, and condemnation of others in preference to self-condemnation follows.

The public overrates the sanitary knowledge of most doctors and it greatly underrates the benefits derivable from the thorough execution of preventive measures and of the means requisite to this end. Even when sanitary officials have, by study and experience while in office, become competent, their wise advice is often rejected, adequate means to secure the results expected are not provided and politicians or the public hasten to replace the old with new officers in order to secure what never will be secured until the public provides adequate means.

During the fifty-five years I have been a citizen of New Orleans and a student of yellow fever the denunciation of our chief sanitary officers in years of yellow fever misfortune has been so frequent that I have been often reminded of an ill-tempered fellow-collegian of my youth, whose dog always accompanied him. Asked why he kept that crippled, ill-fed and unfortunate little dog forever tagging after him, he replied, "Because I must have something near me that I *can* kick when I get *mad*." The public has, again and again, denounced sanitary officers and medical practitioners because they did report cases of yellow fever, and, in 1897 and 1905, because, as was alleged, they failed to report them. Our honored orator on this occasion (Dr. J. H. White, surgeon, United States Public Health Service), now so justly lauded by this and other communities, is a conspicuous example of public injustice, for only a few years ago he experienced the wrath of the San Francisco public because, loyal to truth and duty there as well as here, he participated in reporting cases of the plague.

Since the public has repeatedly damned its sanitary officials and its most reputable practitioners of medicine, because in one year they did report cases, as well as because in another year they did not, can it be wondered at that some of our best sanitarians have refused to be appointed sanitary officials and that the average doctor has striven by silence and inaction to keep out of a mess, wherein, whatever he might do, he would get the worst of it.

Among many instances of publicly denounced sanitary officers that have occurred in my experience I fail to recall one as to which it was not my dispassionate judgment that the public was primarily and chiefly to blame; and I urge you to refrain from all harsh criticisms of sanitary officers or other members of your profession until it be conclusively proved that they have been disloyal to truth and to duty.

While referring to past errors in sanitary matters it has not been forgotten that the present greatly encourages the cheering hope that a juster and a better time for both the public and its sanitary officers is near at hand.

In regard to the prevention of yellow fever, what should you teach, especially to that portion of the public still skeptical as to the efficacy of the preventive measures now advocated by every competent and well-informed sanitarian? You will fail to find, among these skeptics, even one who is well-informed on this subject, and at the same time competent to estimate the value of the knowledge gained during the past seven years. These skeptics will continue to be dangerous to the commonweal until converted, either by the influence of public opinion or by the study and mastery of such facts as you have been taught and as follow:

A Virginian, whose name will be ever famous in our medical annals, Surgeon Walter Reed, of the United States Army, made, by means of laboratory experiments, four momentous discoveries: First, that the female stegomyia mosquito was an agent by which the poison of yellow fever was disseminated; second, that this poison was gained by sucking it from the blood of a person sick with yellow fever during the first three days of the disease; third, that it required not less than twelve days for the poison to mature in the body of the stegomyia before she could infect anyone with yellow fever; fourth, that fomites (*i. e.*, anything, such as infected clothing, believed capable of communicating disease) wholly failed to communicate yellow fever, although heretofore universally believed to be the chief or sole infectious agent of this disease. Every one of these four discoveries, probably the most important ever made for the prosperity of our South, has been confirmed many times by the very best experts possessed by both Europe and America.

In 1901 another Southerner, Surgeon Gorgas, of the United States Army, heretofore a believer in fomites, tested the practical value of Reed's discoveries in Havana, where yellow fever had been present every month for over forty years, with the astounding result that the disease disappeared (and so continued for four successive years) from the longest and worst yellow fever infected locality on earth.

The same preventive measures adopted by Dr. Gorgas in 1901, and that he is now successfully executing in Panama, have, even when insufficiently executed, secured in various places, including many hospitals and asylums, far better results than ever before gained by any of the very numerous preventives that have been tried during the past four centuries of yellow fever history.

Now add to all these facts that comparison of the yellow fever records of New Orleans from 1796 to 1905 with the records of 1905 conclusively prove that there never was before any year wherein there were as many as 57 deaths by yellow fever, as early as July, that was followed by only 460 deaths for the year. On the contrary, our own records fully justify the belief that, but for the warfare on mosquitoes, waged for the first time in this city, which then had a much greater population with very many more non-immunes than in any other such outbreak in July, there would have been not less than 30,000 additional cases and 4,000 more deaths of yellow fever among the men, women and children of New Orleans. Therefore, every citizen who contributed time or money to last summer's holy war, can comfort himself with the conviction that he has to his eternal credit some fraction of at least 30,000 fellow-citizens rescued from suffering and 4,000 of these from death.

The facts now presented fully justify you in teaching that the infected stemomyia is an agent for the dissemination of yellow fever, that this agent is adequate to explain every case of yellow fever and that it is the sole agent thus far conclusively proved. Therefore, the burden of proof that there is some other agent rests wholly on the claimant. In the meantime, while waiting for conclusive proofs of *some other agent,* you will fail in a most important public duty if you do not urge upon every one of the numerous communities liable to yellow fever, that every one of you is about to become a member of, vigorous warfare on the stegomyia.

To wage this war there are three lines of defense: Quarantines, screening the sick, and extermination of stegomyiæ. What should you teach as to these three measures of defense? Quarantines diminish, proportionately to their efficiency, the risks of foreign invasion. They never have excluded all risks during any long series of years. Will they ever accomplish this? An answer demands consideration of the following facts: The most powerful governments fail to exclude all *contraband* goods, much more easily detected than are many cases of yellow fever infected persons and mosquitoes; the rear as well as the front of every place liable to yellow fever must be protected from invasion and to accomplish this our line of defense must be impenetrable throughout the enormous extent of the Mexican border and our own sea-coast, especially throughout our Southern sea-coast, which alone has over twenty quarantine stations from Baltimore to the Rio Grande; and as no chain is stronger than its weakest link, every station, especially those of the South, must be kept *permanently* impenetrable, a favorable result that cannot be reasonably expected, in view of the human tendency always to relax effort after long-continued success, and of other obstacles indicated. Therefore, it is unreasonable to expect *all* quarantines to *always* exclude *all* risks of infection, and hence the public should not, in case of foreign invasion, condemn quarantine officers unless proved guilty of ignorance or negligence.

The screening of an imported case of yellow fever prior to removal from a vessel to prevent any stegomyiæ ashore from becoming infected amply suffices, as has been often proved, to prevent the disease from spreading. But to prevent all risks, in other than such imported cases, the three following requisites are essential: Every case must be screened from the *very beginning* of the attack (certainly as early as the eighth hour, as proved by one experimental case); the screening must be continued during the first three days, proved to be infectious to stegomyiæ, and should be continued, probably, to convalescence, for it has not yet been conclusively proved that stegomyiæ may not become infected after the third day; and the screening should be so perfect that mosquitoes can gain neither access to nor egress from the sick, and such perfect screening necessitates an unusual degree of care (for instance, the fireplace with its open chimney, should not be, as it often is, overlooked) and of experience. There are additional obstacles to preventing by screening *all* risks of spreading the disease.

The ignorant and destitute constitute a large fraction of every population, and many of this fraction are, when sick, never seen by a doctor, and often, if sick with yellow fever, no opportunity is given to detect the disease; hence, it has often happened that the presence of the disease in a community has never been suspected until one of these unfortunates has been sent to a hospital in a dying condition, that is, not until many stegomyiæ have probably been infected and have already communicated the disease to many persons. Further, the majority of yellow fever cases seen by a doctor are not seen at the beginning of the attack, and, even if then seen, the limitations of medical science in diagnosis are so great that it is impossible, at so early a period, to diagnose with certainty many cases of yellow fever. In fact, the imperfections of diagnosis are and have ever been so unquestionable and so notorious, inside of the medical profession, that any doctor who pretended that he could diagnose, not most cases, as can be done, but every case, would thereby convict himself of brazen quackery. For there are some complicated and many mild cases, some of these in white adults and more in children and negroes, that not even the greatest experts can diagnose with certainty. Still further, in these indeterminable cases, the sole obvious symptom present, especially during the first day or two, is fever, the symptom present in most diseases.

The preceding facts in regard to screening fully justify the following conclusions: Even if every doctor in a community did his full duty, as he should be encouraged and even forced to do, to report promptly every case of yellow fever, there would probably remain other cases unknown to any doctor and therefore unscreened; not only every case but also every suspected case should be reported and screened during at least the first three days and probably longer, and among suspected cases should be included every case of fever not *obviously* due to some cause other than yellow fever; the enforcement of annoying sanitary precautions on suspected cases that afterwards prove not to have been yellow fever have always aroused public condemnation and ridicule, and will continue to do so until the public becomes convinced that these precautions, though annoying, are preferable to running the very great risk of suffering the far greater evils of a yellow fever epidemic; inasmuch as most cases of yellow fever are not recognized and screened sufficiently early to prevent the infection of all stegomyiæ, these should be promptly destroyed by fumigation, and, as some may not be killed and others may enter and become infected because of negligent screening, the room and house of the patient should be again fumigated prior to the twelfth day of sickness; and finally, screening, even with fumigation, limited to the houses of the sick and not extended to every house, cannot be relied on except to diminish the risks of infection and thereby the number of cases, therefore the public should not condemn its sanitary officials if this second line of defense fails to yield prompt and perfect results, unless these officials are proved guilty of ignorance or negligence.

The extermination of stegomyiæ, which are town and house-bred and not swamp mosquitoes, is the securest line of defense. Although extermination be incomplete, as it usually is, none the less it is certain that every mosquito killed and every breeding place destroyed will diminish the risks of infection and thereby the number of cases and deaths. Until complete and permanent extermination be accomplished all three lines of defense must be maintained; but whenever accomplished, the first and second lines of defense, so harassing and so difficult and expensive to maintain, will become needless.

The permanent extermination of mosquitoes requires destruction of their breeding-places, that is, riddance of all of the very numerous receptacles of stagnant water that may be fishless, accessible to mosquitoes, and stagnant as long as eight days after the entrance of mosquitoes, for it requires at least nine days for the egg to develop into the blood-sucking adult. To get rid permanently of all breeding-places the chief requisites are the establishment of an adequate water supply, of drainage, sewerage and pavements—improvements long urged by sanitarians and now in course of construction in New Orleans.

The culicidal agents that exterminate stegomyiæ also destroy other species of mosquitoes. It has been conclusively proved that three diseases are due to three different species of mosquitoes, and it is claimed, and it is very probable, that there are several more. Among these diseases is malarial fever, a more persistent and destructive foe to Southern prosperity than occasional yellow fever. In this fact you have strong additional reason to urge incessantly on the people the wisdom of exterminating *all* mosquitoes. However difficult and expensive this task may prove to be its accomplishment will yield returns a thousandfold by increase of public health and wealth.

In all civilized countries liable to either malarial or yellow fever warfare on mosquitoes is now advocated, and every year increases the number of places that have inaugurated this war. The results have been so much more favorable than ever before secured, even when the preventive measures have been insufficiently executed, that it is marvelous that even skeptics should hesitate to lend their efforts to secure at least a fair trial of measures that inspire sanitary science with the greatest confidence that the day is not very distant when suffering humanity will be permanently relieved of the direful injuries inflicted on health and prosperity by these two disastrous diseases, malaria and yellow fever.

By far the most important result of last summer's prevalence of yellow fever was the conversion of a much greater number of citizens than ever before to due appreciation of the measures and of the cost necessary to prevent this disease; the public of New Orleans responded with such courage and patriotic devotion to the execution of preventive measures that greater confidence in the future than ever before is justifiable. The greatest danger that threatens the future is the forgetfulness, so usual after years of freedom from injury, that the price of public health, as of liberty, is eternal vigilance. There is no forgetfulness as to the coming summer, and, if the preventive measures that have been and are now being executed in New Orleans continue to be efficiently prosecuted, it is probable that there will be no cases of yellow fever, or, if any, so few that all the injury that may be done to the public health will be more than compensated for by the diminished injury from malaria and other diseases.

In bidding you, graduates of 1906, farewell, all your teachers unite in hearty congratulations on the satisfactory completion of your numerous collegiate studies; and they also unite in *hoping* that your interest in the welfare and your support of your college will not lessen, that you will often return to replenish your knowledge by means of the improved educational advantages the future has in store, and that your careers may be distinguished by notable benefits to the people and by happiness and prosperity for yourselves.

Pathology.*

By CHARLES W. HEITZMAN, M. D., Muskogee, Indian Territory.

"Lives of great men all remind us
We can make our lives sublime,
And in parting leave behind us
Footprints on the sands of time."

Turn near the center of Boulevard Pasteur, in the City of Paris, and you will find yourself in the Rue Dutot. Here rises up a building that is in a sense the monument of a man whose career stamped him as one of the greatest men of genius of any race or any time. The body of Pasteur rests in a crypt at its base. Though he be dead yet his spirit animates the institution still, and it is fitting that his body should rest in the worthy mausoleum within the walls of that building whose erection was the tangible culmination of his life labors. The sarcophagus is a shrine within this temple of science which will serve to stimulate generations of workers here to walk worthily in the footsteps of the great founder of the institution, for he must be an unimaginative person indeed who, passing beneath the arch bearing the simple inscription, "Ici Repose Pasteur," could descend into the simple but impressive tomb and stand beside the massive granite sarcophagus without feeling the same kind of mental uplift which comes from contact with a great and noble personality. The pretentious tomb of Galileo in the nave of Santa Croce at Florence, and the crowded resting place of Newton and Darwin in Westminster Abbey, have no such impressiveness as this solitary vault where rests the body of Pasteur, isolated in death as the mightier spirits must always be in life.

The final demonstration that all organic action is in the last resort a question of cellular activities, and, specifically, that all abnormal changes in any tissues of the body due to whatever disease can consist of nothing more than the destruction, or the proliferation, or the alteration of the cells that compose the tissue by "The Father of Pathology," gave the proper scientific rank to pathological anatomy. This discovery (about 1865) made him famous and from that day to this the name of Virchow has held the same position in the world of pathology that the name of

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*Address by the Chairman, read at the Oklahoma State Medical Society Oklahoma City, May 7-8-9, 1906.

Pasteur occupies in the realm of bacteriology. The Institute of Pathology, in Berlin, stands as his monument, and while he is gone his influence will not soon be forgotten. The pupils of a great teacher are sure to carry forward the work somewhat in the spirit of the master for at least a generation.

The rapid advancement of medicine as a science began with our more intimate knowledge of pathology. Our knowledge of pathology is increased by our increased knowledge of the cell and its mechanism; in other words, cellular activity. While much has been learned about the cell of late, that interesting microcosm still offers a multitude of intricacies for solution. Our ultimate knowledge of disease must at last come through our understanding thoroughly the mechanical construction of the cell. One theory advanced is that the substance of the typical cell is essentially alveolar, or foam like, comparable to an emulsion, and that the observed reticular structure of the cell is due to the intersection of the walls of the minute ultimate globules. But another equal authoritative theory is that the recticulum is really a system of threads, which constitute the most important basis of the cell structure. It is even held that these fibres penetrate the cell walls, and connect adjoining cells, so that the entire body is a recticulum. Perhaps both contain a measure of truth. Again it is a question whether the finer granules seen within the cells are or are not typical structures capable of assimilation, growth and division and hence to be regarded as elementary units of structure standing between the cell and the ultimate molecules of living matter. The more philosophical thinkers believe that such intermediate units must exist, whether or not the microscope reveals them to view. An elaborate hypothetical scheme, by Weismann, of the relations of the intercellular units identifies the larger of these units not with the ordinary granules of the cells, but with a remarkable structure called chromatin, which becomes aggregated within the cell nucleus at the time of cellular division—a structure which divides into definite parts and goes through some most suggestive maneuvers in the process of cell multiplication. All these are puzzling structures, and there is another minute body within the cell, called the centrosome, that is quite as much so. This structure has been regarded as essential to cell division, yet some recent botanical studies seem to show it is altogether wanting in a dividing cell.

In a word, the architecture of the cell has been shown by modern research to be wonderfully complicated, but the accumulating researches are just at a point where much is obscure about many of the observed phenomena. The immediate future seems full of promise of advances upon present understanding of cell processes. If the American profession would turn their guns on the study of the cell and the consequent findings in pathology with the same energy and success that we have in the technique of surgery what a story we could write. During the past year among the newer methods used for pathological findings may be mentioned Klunse and Schaer's test for occult blood in the feces. The detection of minute traces of sugar in the urine by the use of phenylhydrazin hydrochlorate (one gram) and sodium acetate (two grams), boil specimens for one hour, cool and examine sediment microscopically. The typical sugar crystals are delicate sulphur yellow crystals, arranged in sheaths. In addition to these one usually finds thorn apple crystals, due to minute traces of sugar. The importance of bacteriological examination of cadavers and blood cultures has been emphasized; the method of diagnosing lues by means of the spirocheta pallida and its staining, Goldhorn's stain seemingly the more practical. Again, the discussions regarding the diagnostic value of tuberculin have claimed space in various journals, as have experiments with tuberculins made from human and bovine bacilli. Surgical scarlatina from various authors has been decided to be nothing more than scarlet fever in the wounded. Hektoen, after going over the various reports of successful inoculations of measles, concludes that the major etiologic factor is in the blood. The subject of immunity has, and will for some time, occupy a high place in all discussions in pathology; much, however, has been added to our understanding knowledge of it. Pathology has, during the past summer, added a new laurel to its crown in the successful fight against yellow fever, demonstrating "no mosquitoes, no yellow fever." The workers in the etiology of variola and histology of vaccinia and variola and of the skin have added their experience to the good. Ankylostoma infection, especially through the skin, sheds more light on the interesting cause of many cases of pernicious anemia. The parasite theory of carcinoma is still a question; Von Leyden believes it to be an infectious disease but local. Orth says up to the present no one has produced proof that carcinoma is of parasitic origin. Rosenow has found the pneumococcus in the blood of lobar pneumonia in ninety-one per cent. of cases. Much has been accomplished in the study of histogenesis of the tubercle in the frequency, location and mode of dissemination of tuberculosis with special reference to its occurrence in lymp nodes and during childhood. Medical literature for the past year has also contained many articles of more or less value relating to the pathology of the organs of the abdomen and pelvis and of the nervous and locomotor systems.

The Early Diagnosis of Malignant Tumors, with Special Reference to Cancers of Breast, Uterus and Stomach.*

By ADRIAN A. LANDRY. M. D., Paincourtville, La.

"A careful study of the pathology and histology of malignant tumors," writes Senn, "as well as the results of accurate clinical observation, has demonstrated that malignant tumors are primarily purely local affections amenable to successful surgical treatment, and that they become general only by the dissemination of tumor cells through the systemic circulation." This admitted, we can readily see wherein lies the responsibility in the successful solution of the cancer problem—with the one who first sees the case, the family practitioner as a rule.

There is no more responsible duty devolving upon the general practitioner than the diagnosis of this disease, for the failure to do so may mean the sacrifice of a human life. We should be prepared to recognize the disease in its incipiency, when it is still a purely local affection amenable to successful surgery. We should devote our sincerest efforts to the clinical study of the disease, that the advice so confidently sought of and the faith so implicitly vested in the family guardian in health and disease be not placed amiss, and he who is not able, when confronted with an incipient cancer, to at least suspect malignancy and give advice accordingly, has not done his whole duty, has not expended his best efforts in his preparation for that noblest of callings, the healer and assuager of human ailments.

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*Read at the Quarterly Meeting of the Assumption Parish Medical Society.

In the past few years a vast amount of time and money has been spent by patient and devoted investigators and philanthropists in the study of cancer, with so far but little practical result. The etiology and mode of transmission of the disease, a knowledge of which is so necessary to its successful treatment, still remain a mystery. We have to rely, as of old, upon complete extirpation of the malignant process before the infection is even regional. If we let pass the golden opportunity of making an early diagnosis, all is lost, and our patient is doomed to the most horrible of deaths.

It is our purpose to consider briefly the clinical characteristics which have appealed to us as suggestive of early malignancy in tumors of the breast, uterus and stomach, considering the clinical features of cancer of the breast as applicable to all external cancers.

1st. Rapid growth is one of the main clinical features of malignancy and should of itself enable us to make a positive diagnosis. It is safe to assert that all rapidly growing tumors are malignant, and that their degree of malignancy is in direct proportion to their rapidity of growth. The rapidly enlarging nodule in the breast, the small papilloma of the lip which suddenly takes on a proliferating and ulcerating aspect, the bone tumor showing an undue activiey, should all be viewed with suspicion regardless of other signs or symptoms. It is true, however, that some types of epithelial carcinomas are at some stage of development of extremely slow growth and even latent, but these are rare, and their existence would not affect our general law that all rapidly growing tumors, exclusive of inflammatory swellings, should be regarded as malignant. Tenderness, very marked in an inflammatory swelling and absent in malignant tumors, is an important feature in differentiating the two affections.

2d. The tendency of malignant tumors to invade surrounding tissues and to recur after removal is another characteristic. Benign tumors are always encapsulated, and if the enveloping capsule is entirely removed, there will be no recurrence. Malignant tumors, although they may seem circumscribed, always show a tendency to invade surrounding tissues, and unless removed early before general or even regional infection occurs, and thoroughly extending incisions wide of tumor into apparently healthy tissues, recurrence will be certain. This tendency to invade surrounding tissues in malignant tumors is sponsor for another characteristic, immobility. It is readily appreciated that a tumor which is pervading an organ, diffusing itself rapidly into surrounding structures, should form one mass with that organ. This is typically seen in cancer of the breast, where the tumor and the gland soon form one whole mass, adherent to skin and thoracic walls.

3. Pain, spontaneous and of a lancinating and paroxysmal character, with nocturnal exacerbations, was for a long time regarded as a distinctive characteristic of malignancy, but is misleading, and no undue weight should be attached to its presence or absence. Pain is not characteristic of early cancer. It may be present and it may not. It is at times absent even in advanced cases. Besides, pain may be severe in benign tumors. Senn asserts that, in his experience, adenoma of the breast is much more painful than early cancer of the same size. We can all recall instances where the absence of pain was a prominent clinical feature of cancer, although far advanced.

4th. Retraction of the nipple, so often referred to as typical of cancer of breast, should not be looked upon as a very important sign. It may or may not be present. Its presence argues in favor of malignancy, although it obtains in about five per cent. of chronic inflammatory conditions, but too much importance should not be attached to its absence. In cancers of the periphery of the breast it may not occur until late, and in very rapidly growing tumors it may not be present at all.

Finally redness, edema of the skin, the development of nodules which run together producing a hard brawny patch, eventually ulcerating, the involvement of lymphatic glands and the development of the characteristic cachexia, are all late symptoms, which should not be awaited for before having recourse to radical treatment.

CANCER OF UTERUS.—With the three classical symptoms, hemorrhage, discharge and pain, the diagnosis is self-evident. No examination is necessary; he who runs may read. It is also self-evident that the case is beyond surgery, or any other remedial measures so far as cure is concerned; palliation is all that can be expected. It is imperative, therefore, to make a diagnosis before the advent of these cardinal symptoms by the correct interpretation of each as it presents itself. In the great majority of cases, hemorrhage is the first symptom to present itself. During menstrual life, profuse and irregular menstruation, with occasional spotting after coitus, straining at stool or exertion should be carefully investigated, especially if accompanied with a leucorrhea. Post-climacteric hemorrhage, be it ever so slight, is almost pathognomonic. As in menstrual life, it first appears after coitus, straining or exertion. Other conditions may occasion hemorrhage at this period of woman's life, such as polypi, etc., but as a rule this is so seldom the case that it is safe to consider this symptom with the utmost concern, demanding not only the most thorough physical examination, but microscopical examination of suspected tissues. Nothing should be left undone to arrive at a correct diagnosis at this stage of the disease, for it is now that surgery offers the only hope of a radical cure.

The discharge at the incipiency of the disease presents nothing characteristic. It is mucous or muco-purulent, as in leucorrhea. Later it becomes serous, watery and sero-sanguinolent, and should of itself arouse our suspicions. The foul and putrescent discharge of ulceration and saprophytic decomposition is pathognomonic, but unfortunately at this stage of the disease surgery offers nothing but a short-lived palliation.

As to pain, its appearance augurs ill for the patient, the case being then practically hopeless from a curative standpoint. As in cancer of other organs, little significance should be attached to this symptom. It is seldom complained of in early cancer and when present is generally due to other conditions.

Physical examination reveals in incipient cancer of cervix a nodular and indurated condition of the cervix, the lips being thickened, with or without ulceration, bleeding easily on manipulation; the mucous membranes may show nodules having a glazed bluish appearance as though ready to burst, or an ulcer with a glazed surface presenting delicate projections with a hemorrhagic tendency, the surface of the ulcer being uneven with a hard indurated base. If the disease involves both lips, the opening of the cervical canal is surrounded by a firm ringlike induration, which does not yield on attempting to insert the finger. The characteristic hardness and nodular condition of the cervix, with the tendency to bleed on the slightest manipulation, will differentiate cancer from erosions, lacerations and hypertrophies of the organ. As the disease progresses, the disintegration of the cervix, the cervical landmarks being obscured and eventually obliterated by cauliflower excrescences, the hard nodular base and surrounding tissues, etc., making the diagnosis self-evident.

The responsibility of the physician, however, does not lie wholly in the making of a diagnosis when the patient presents herself, and the recommendation of a radical procedure. As guardian of the physical welfare of those who place their confidence in him, it is his duty to so instruct them in the significance of certain pudendal symptoms that they may assist in the early recognition of this terrible disease. The patient's attitude has undoubtedly assisted many times in contributing to her own destruction. Women are wont, as a rule, to look upon slight hemorrhage and discharge, especially occurring during the fourth decennium, with little concern, of no particular consequence, patiently to be borne. The ignorant, ubiquitous, and "always-ready-to-give-advice" old granny is ever teaching that such symptoms are frequent and necessary evils to this period of a woman's life, and will pass away with the change of life.

Woman's natural aversion to physical examination and the fear of operative procedure assist in the delay, and as a rule our patient does not seek advice until the symptoms become alarming. When admonished as to her postponing seeking medical advice, she replies, "I suffer no pain," having been taught to consider pain as the first symptom of malignant disease.

Four years ago I remember being consulted by the mother of a physician, a person of more than average intelligence, over fifty years of age, complaining of occasional hemorrhage, of late profuse, and accompanied by a watery discharge. Upon my expressing a fear of malignant disease, she replied: "It cannot be, for I suffer no pain whatever." Examination revealed an already inoperable cancer of uterus, although her general condition was as yet excellent.

It is our duty to teach our patients that pain is not a necessary accompaniment to malignancy in the early stages, that it is a very unreliable symptom, one to which we must attach very little importance. The absence of pain does not signify the absence of cancer.

Hemorrhage and discharge, symptoms to which they attach little importance, we must teach them to consider of grave import, especially after the menopause, always of sufficient gravity to demand medical advice. However slight the hemorrhage at this period of life, we must impress women to regard it with concern and suspicion. In earlier life we should teach them that profuse menstruation and irregular hemorrhages, in the absence of frequency, deserve—nay, demand—attention, and the physician, when consulted, falls wide of his duty if he content himself with simply giving a prescription and general advice. A leuchorrhea, which in course of time changes in character from mucous or muco-purulent to watery or sero-sanguinolent, we must teach them to look upon also seriously, even if unaccompanied by hemorrhage. A watery, acrid discharge, occasioning often a pruritis vulvæ, is always significant of cancer. Until we have impressed these facts upon our patients, we have not done our whole duty. It is true that pudendal hemorrhage and a discharge do not always indicate malignant disease, but they are always expressive of some pathological condition requiring the benefit of medical skill. Strange as it may seem, it is nevertheless a fact that women who live in a constant fear of cancer and consult their physician for the slightest symptom, are proverbially free from the disease. It is not at all improbable that the prompt attention to minor troubles of the uterus may act as a form of prophylaxis. By keeping the mucous membranes of the uterus in a permanently healthy condition, the ideas of preventive medicine are being carried out as far as possible.

CANCER OF STOMACH.—Surgery of the stomach has made such rapid strides of late that in cancer of this organ it offers not only palliation and a deliverance from that most horrible of deaths, starvation, but even a cure in a fair percentage of cases, as the work of Mayo, of Rochester, Minn., in this direction, will bear out. Here, again, success lies in an early diagnosis, but, unfortunately, in the light of our present knowledge, even with our modern clinical and laboratory methods, a certain and reliable diagnosis of incipient gastric cancer is an impossibility. A strong suspicion of malignancy is as far as we can go.

We should suspect cancer in a patient who, having been in fair health, gradually loses vigor, becomes emaciated and anemic, and develops gastric symptoms, slight and obscure at first, but prominent later on. The gastric symptoms are always mild and apparently out of proportion to the steadily increasing general debility, anemia and emaciation, and persist in spite of treatment, diet, etc. There is nothing characteristic, however, in the symptoms themselves, the anorexia, eructations, nausea, vomiting, constipation, diarrhea, hematemisis, gastric distress, etc., being seen in other conditions. Pain here, as in malignancy in other organs, is unreliable, being as a rule more severe in ulcers. It is the lack of correlation between the gastric symptoms and the general debility, in the absence of other causative conditions, that should lead us to suspect malignancy.

As an ulcer is often transformed or degenerates into cancer, we should be on our guard and consider suspicious an intractable ulcer, which has resisted rest and appropriate treatment, or an ulcer latent for some time, which presents symptoms of recurrence after an apparent cure.

With a diagnosis of suspicious malignancy in stomach, in the light of recent advancements in abdominal and gastric surgery, our duty is plain if we wish to give our patients the benefit of modern surgery. We should urge an exploratory operation to settle the diagnosis in the first place, and should our suspicions prove correct, to adopt whatever methods may be necessary for a radical cure or palliation. As a matter of prophylaxis, it is contended, and we believe justly so, that should the exploration reveal an ulcer, especially a chronic one, it should be excised, thereby relieving our patient of an etiological factor in this dreadful disease

"Altruism has Limitations, and Charity Begins at Home."*

By B. A. COLOMB, M. D., Union, P. O., La.

"He who destroys himself by helping others may be noble, but when we think of his poverty-stricken widow and orphans he shrinks into ignobility. The solution of the matter would come, if none but the rich should study medicine, and the profession cease to be a means of livelihood—and this absurd proposition has been gravely suggested by one writer. The basis of any organization is the law that each unit can help itself while helping others, and consequently no profession can survive unless it is one of the means by which some can struggle for existence. It must be a money-making business or it will be unnatural. As well might we demand that farmers work for nothing, as we would perish unless they gave us food."—*American Medicine.*

The individual member of the county medical society is the ultimate particle in our professional organization. He bears the same relation to the general body of medicine that the individual cell bears to the entire human body. As the effectiveness of any organized substance is in direct ratio to the hearty activity of its component parts so will the usefulness of our society depend upon the work done by each member for the general good. One isolated cell in the human organism could accomplish but little of itself, but a number of them laboring together in a uniform and mutually dependent way make up the various organs of our bodies, upon which depend its form, its various functions and its very existence. The various organs themselves could subserve no useful purpose unless they were united into one complete body and each contributing its share towards the perpetuation thereof—always alert to meet any harmful conditions that might arise from within or threaten from without, and ever willing to labor for its upbuilding.

In this manner is the medical profession now organized. We join our county society, if eligible for membership, and become *ipso facto* members of the State society. We do not, however, become members of the American Medical Association, but merely align ourselves with the parent society. If we would get the full benefits from our organization we must become members of the American Medical Association and keep in full touch with all that is going on for or against us. Anything affecting the body of our profession, like our own bodies, is felt first by the cell or ultimate element. We are the terminal filaments, as it were—right on the firing line—and should know what we are contending against and what our means of defense. All the perplexing conditions and questions that arise come floating by in a kind of endless blood-stream, out of which we must select the good, and into which we must throw the bad. When the patent medicine men send out their tons of literature we get it. When the great manufacturing houses have anything special to introduce they turn to us. When the insurance companies find out they are spending too much—poor devils—they begin to retrench down where we live. While on this subject I would call your attention to the fact that every one of these dishonest manipulators of other people's money is reducing the fees of country examiners to $3. We rarely ever examine for policies over $3,000 and have usually to ride several miles to see an applicant. This reduction is done on the plea that the recent investigations have made retrenchment necessary. In other words, there will not be so much money to benevolently assimilate in the future, because they have been caught in the act and to restore the manipulative surplus these poverty-stricken corporations now all come forward with a uniform minimum of fees. I would further call your especial attention to the following facts in this connection: The New York Life Insurance Company reduced its examination fee some years ago on the plea of economy, and we now know that since that time up to a few weeks since there never was such wasteful, reckless and dishonest expenditure of other peoples' money as was done by the officers of that corporation. Anyone who reads will know that the Standard Oil Company and similar influences have come into control of the large insurance societies and the natural inference is that the future management is likely to be worse than the past. What is the medical profession going to do about it? When the blood current becomes foul the cell rebels; unless it is purified the cell sickens and then dies. We do not realize what is due us and have no conception of our own power when acting in concert. We are much like the people of Russia that have been trampled upon for so long that the weight of a heel upon their necks has grown to be quite a natural sensation.

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*Read at the March meeting of the St. James Parish Medical Society.

The great burden of the medical profession is carried by the man on the firing line. The reforms should be set in motion by him and work upwards. He should remember at all times that whether in business, war, medicine or any other calling, even in life itself, to be supremely effective he must be united into a complete and harmonious organization, laboring with a fixed purpose and every unit doing its work well.

Clinical Lecture—Tinea Favus Papillaris.*

By J. V. SHOEMAKER, M. D., LL. D., Professor of Materia Medica, Therapeutics Clinical Medicine, and Diseases of the Skin in the Medico-Chirurgical College and Hospital of Philadelphia.

This boy, aged 6 years, nativity America, complains of itching of the scalp with crust formation—the hair falls and there are areas of baldness over his scalp where the skin appears atrophied with the presence of small cicatrices. The crusts present are pea-sized, cup-shaped, and yellowish in color, having a slightly mousy odor. One of these crusts was removed with a pair of forceps, powdered, fixed and stained on a glass slide, and examined under the high-power microscope, 1-12 oil immersion lens, which revealed the presence of the fungus achorion Schönleinii, consisting of mycelium and spores. This confirmed our diagnosis of favus. There are three other children in the family, but he is the only one that has the disease, notwithstanding its contagion. Fifteen months ago the mother noticed small yellow crusts on his scalp; soon more appeared. She applied salves, but failed to get rid of them.

Favus may be limited to the hairs and the hair-follicles (tinea favosa pilaris), to the epidermis (tinea favosa epidermis), to the nails (tinea favosa unguium), or it may involve the entire surface and all of the cutaneous appendages (tinea favosa universalis).

This boy has tinea favosa pilaris, the most common form, and should be differentiated from tinea tonsurans and pustular eczema. The tables on the blackboard give the chief differential points of the diseases named:

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*Delivered in the Clinical Amphitheater of the Medico-Chirurgical Hospital.

Tinea Favosa Pilaris.	*Tinea Tonsurans.*
(1) Caused by the fungus achorion Schonleinii.	(1) Caused by the vegetable parasite tinea trichophyton.
(2) The crusts are dry, yellow, friable and cup-shaped.	(2) The crusts are due to the exudative vesicles and pustules.
(3) The hairs drop out of the follicles.	(3) The hairs break off and look nibbled.
(4) A musty odor is present.	(4) No odor.
(5) Chloroform does not affect the hair.	(5) Chloroform turns the hair white in a few minutes.
(6) Area affected is bald and atrophic with small scars.	(6) Area affected looks stubbled by the broken-off hairs.

Tinea Favosa Pilaris.	*Pustular Eczema.*
(1) Caused by the vegetable parasite achorion Schonleinii.	(1) Cause constitutional.
(2) Crusts yellow, dry, friable and cup-shaped.	(2) Crusts brownish, due to exudation.
(3) Hairs fall out of the follicles.	(3) Hair not affected.
(4) Parts have a musty odor.	(4) Parts have no odor.

In tinea favosa papillaris the parasite penetrates into the hair follicles, and insinuates itself between the superficial cells of the corneous layer. It also attacks the inner and outer root sheaths of the hair, and may even invade the hair shaft. Obliteration of the hair follicles and atrophy of the hair papillæ finally result from the continuous pressure of the parasitic growth. Various inflammatory and atrophic changes take place in the corium from the same cause. Suppuration and permanent cicatrices may or may not occur. The crusts are composed almost entirely of mycelium and spores of the achorion Schönleinii. The mycelium consist of narrow, flattened threads or tubes ramifying luxuriantly in all directions. They are pale green or gray in color, and vary in diameter. There are two varieties of mycelial tubes or threads; those which are apparently empty, and those which are divided in small compartments containing numerous granules or young spores. The fully developed conidia or spores are round or oval bodies, varying in diameter and form. They are present in great numbers and are frequently massed in groups. Often forms intermediate between spores and mycelium are found.

The disease is produced by the growth of the achorion Schönleinii, a vegetable parasite attacking the follicles and the upper corneous layers of the epiderimis. The disease is propogated by contagion, yet in many patients, as in this case, a history of direct contagion cannot be established; in these cases it is probable that the spores of the fungus are transmitted through the medium of the atmosphere. Favus may occur at any age, and among the rich as well as among the poor. It is, however, met with most frequently in scrofulous children. The susceptibility of individuals to its contagion varies greatly and it is probable that a peculiar condition of the integument is necessary to its continued existence—filth being a predisposing factor. The disease is exceedingly common among the lower animals, especially in cats, mice and rabbits.

The treatment is chiefly local, but in this boy it must be constitutional as well. He is anemic, poorly nourished, and of a strenuous diathesis, consequently nourishing food, such as milk and eggs, fresh air, plenty of sunlight and healthful exercise are of paramount importance to build up the economy. Internally we cannot give him anything better than syrupi ferri iodidi, m. xx, after each meal. The local treatment consists in destroying the parasite, which requires persistent applications of a parasiticide. First, we must remove the crusts, which is best accomplished by the application of some oil or fatty preparation. The oil of ergot may be used for at least twenty-four hours. This softens and loosens the crusts and produces a mild astringent effect upon the epidermis. A detergent lotion, such as a 25 per cent. solution of boroglyceride, should follow to cleanse the affected parts and abstract the moisture, which is so essential to the growth of the fungus. As an anti-parasitic mercuric chloride has no rival, but in favus it coagulates the albumin in the epidermis, forming a protective layer of mercuric albuminate over the follicles, beneath which the parasite may live in security and thrive. But the anti-parasitics *par excellence* are the oleates of mercury and copper. They give the best results when used either in 5 or 10 per cent. ointment. A little of either ointment is rubbed in well with the finger tips once or twice a day. No irritation as a rule results, but on the contrary speedy disappearance of the fungus by the use of these applications follows. Application of one or the other of these preparations should be made continuously every morning and night until the disease disappears. To determine when the disease is cured, a single hair should be extracted and examined microscopically for the presence of the fungus. Water, or the use of soap and water should be interdicted, as they invariably increase the activity of the parasite. The skin should be cleansed with oil and borax or boric acid, alcohol and ether. The X-Rays, formaldehyde and the preparations of sulphur are likewise all good parasiticides for the treatment of favus. It is subject to relapse in all instances, unless the parasite is entirely extirpated. When the parasite has been growing for a considerable period permanent contagion and baldness result from the ravages of the fungus. Sometimes the disease involves the mucous membrane and under such circumstances the disease is usually fatal.

N. O. Medical and Surgical Journal

Editorial Department.

CHAS. CHASSAIGNAC, M. D. ISADORE DYER, M. D.

The Meeting of the State Society.

One of the most successful meetings of the Louisiana State Medical Society was held in New Orleans on the 8th, 9th and 10th of May. In point of attendance it surpassed any previous meeting, the registration being 344. The several sessions of the Society were interesting and the papers read of a high order of excellence. The business side of the meeting was promptly executed and the enthusiasm which was present throughout found its final expression at the banquet which was held at the Rathskeller on the night of May 10.

The importance of thorough organization of the regular practitioners in the State of Louisiana is more and more evident as each year sees the gathering of the Society, and while its membership has grown twofold during the past four or five years there still remain several hundred eligible candidates for membership throughout the State. The dues of the Society are as small as they could be consistent with the needs of the Society and the privileges afforded the members. More than this, the respect for a large body of medical men must carry some weight in vital questions affecting the general public and it is to the interest of every practitioner to affiliate himself with an organized body rather than to drift into the isolation which individual methods are bound to create.

The education afforded by the mass of miscellaneous medical pabulum provided at one of these meetings is inestimable and it is only when the several articles are read at leisure throughout the year that the real purpose of these is appreciated.

Several conclusions thrust themselves upon us in reviewing the recent session. The first is the intense interest expressed by the large attendance and the high character of the papers presented. Owing to the length of the program many of these were read by title. This suggests that another year it would be well to restrict the program to topics of paramount interest so that the program may not be crowded with too large a number of titles impossible of completion during the time at the disposal of the officer who presides.

In a most excellent address delivered by the incoming president at the banquet of the Association the suggestion was dropped that hereafter all papers should be read in abstract and so as to stimulate a more extended discussion and not to occupy too much of the time of the Society in reading papers of length. The way in which this suggestion was received argues its favorable acceptance by the membership as a whole and it is not untimely to record this idea in order that it may grow into some force during the year to come.

The presence of Dr. James Carroll and Dr. W. H. Sanders and their contributions to the symposium on the Sanitary Control of Yellow Fever added materially to the interest of the meeting. The progress along scientific lines among our own profession during the past few years leads us to express the opinion that it would be wise to stimulate the attendance of distinguished guests from other states at future sessions for the mutual advantage of acquiring ideas and methods which their intercourse is bound to provoke.

Elsewhere the JOURNAL is publishing a general report of the meeting and we may be permitted to conclude with an expression of congratulation for all of those responsible for the success of the meeting, which was attended with remarkable harmony, earnestness of purpose, valuable discussion and a promise of future and similar achievement.

Legislation for Patent and Proprietary Medicines.

Resolutions were presented at the meeting of the State Society regarding patent and proprietary medicines. Very properly the matter was deferred for future consideration and the resolutions submitted to a special committee to consider the various phases of the question and to report at the next meeting of the Society.

Various and sundry agitation has already been practiced along this same line by the National Congress, individual States, lay periodicals and by the American Medical Association itself. At this time it is rather difficult to assume any fixed position on the question because a motley argument is advanced as to the method of attack against the impositions upon public credulity.

Resolutions have gone forth from various medical societies encouraging the lay periodicals to further attacks upon the patent medicine habit, and also aiming at some legislation.

A long time will be required to clear the decks for real action in the fight against the evils which are covered by the question under consideration. So far only a limited number of patent medicines have been entertained in legislative enactments proposed. All of these are directed at the advertised nostrums which contain either acknowledged poisons or a high percentage of alcohol.

A rational review of the list of newspaper advertisements, padded literature and the sample list which yearly comes to the physician's office will show a long list of remedies which fall outside of the above class. The average drugstore even would give food for profound study of the question at issue. Here the most of the shelves are filled with a fine assortment of color schemes, each carrying preposterous labels with vaunted success in a long catalogue of human ills. Most of these are preparations which come from all parts of the civilized world, but many bear the label of home manufacture, showing that the druggist himself is party to the evil, or shares with the local manufacturer the burden of blame.

Any legislation which is directed at patent and proprietary medicines must be comprehensive and at the same time sufficiently qualified so as not to include those compounds which are recognized and acceptable in the practice of medicine.

It is said that the reputable manufacturers of drugs and compounds are themselves working to the end of protecting their preparations, and, incidentally, the public, from the overflow of nostrums at present circulated. We believe that this is in large part true, but the medical profession owes it to itself to fight this battle from its own camp, as it cannot afford to discount a pure purpose by any combination with allies whose object may have a qualified interpretation.

Meantime the public is gradually reaching a point of education which may lead them to appreciate the need for protection, and this education should be encouraged to a practical point of assistance. The Pure Food Act has done a great deal towards starting an opening wedge in the patent medicine question and the revision of the National Formulary and Pharmacopeia has also accomplished much in aiding the same object by recognizing certain proprietary remedial agents and by establishing as official combinations devised by reputable pharmaceutical houses.

All of this needs to be thoroughly digested and whatever is finally arrived at as a probable solution of the question must be clear cut and free of imputation of sordid motive, for, while the medical profession has a right to protect its dignity and even its commercial privileges, it should be along lines which must be recognized as consonant with the public welfare.

Refutation of Harlequin's Attack on the Senses Hospital.

In the April 5th number of *Harlequin* was published an article headed "Quackery," which was an attack upon the medical charitable institutions of New Orleans, aside from the Charity Hospital, but aimed almost exclusively at the Eye, Ear, Nose and Throat Hospital. That there was a special animus on the part of somebody back of this publication is shown by the fact that a reprint of this article was sent to the members of the medical profession at least, if to no one else.

The claim is made that for selfish reasons free services are given indiscriminately to the public, and that such as are turned away are referred to members of the staff for treatment.

It is surprising that *Harlequin* published this defamatory article without any apparent investigation as to its truth. We understand that the members of the Board of Trustees of the medical staff of the Senses Hospital have not regarded it as worthy of reply, but that the suggestion was made to *Harlequin* that the matter should be investigated and the truth or falsity of the article be given to the public. As far as we know nothing further has been done on either side, and we must protest at this unwarranted attack upon one of our foremost medical institutions.

As a matter of fact the Senses Hospital is the one that makes the most strenuous efforts to prevent imposture and to turn back to the physicians patients whom they have the right to expect shall consult them. Certificates are usually required, and must be signed by physicians, hence, it is the fault of the latter in some instances if any impostor receives free treatment.

It is scarcely necessary to attempt refuting in detail the charges made in the article in question, but it might be said in passing that when the Orleans Parish Medical Society made strenuous efforts in the past to have the question of free treatment at clinics properly regulated by our medical institutions, the Eye, Ear, Nose and Throat Hospital was the one which was most ready to co-operate, and the committee charged by the Society with the work recommended in conference with representatives of the other institutions that the plan of the Senses Hospital be followed.

As *Harlequin* has failed to make any attempt at amends we feel in duty bound to express our emphatic opinion on the subject.

Abstracts, Extracts and Miscellany.

Department of Surgery.

In Charge of Dr. F. W. Parham, Assisted by Dr. F. Larue, New Orleans.

Intestinal Obstruction.—Dr. Howard Lilienthal, in the *New York Medical Journal* of April, 7, 1906, in a paper read before the Harvard Medical Society of New York, makes some good points with regard to intestinal obstruction with the following hints on the technics of operations for acute intestinal obstruction:

"General anesthesia is to be preferred to local anesthesia, except in the case of patients who are almost moribund. Preoperative gastric lavage should always be practiced. If there is a mass, make a small incision over it and explore with the finger. If it becomes obvious that this mass is the cause of the trouble the incision may be enlarged and the operation proceeded with. If there is no mass and no point of greatest tenderness, a small median incision should be made. Distended gut will be encountered. Collapsed gut, if present, may not be at once found. If the acute form has occurred as the terminal complication of a chronic obstruction, there will be enormous hypertrophied as well as distended intestine. I have seen ileum twelve inches in circumference in a case of ileocæcal carcinoma, and yet the tension was not as great as that in distended intestine of much smaller size following acute obstruction. If there is distended large intestine the location of the obstruction may be guessed at once within a few feet. If large intestine is collapsed and small intestine alone distended the search may be more troublesome, and it may even be necessary to work upward from the ileocæcal valve along the small intestine until the point of obstruction has been reached. It is of the first importance to locate the obstruction; its accurate diagnosis may come later.

If gut is under very high tension it is dangerous to manipulate it. Such gut had better be emptied at once and the obstruction sought afterwards. The emptying of distended gut is a delicate operation and must be performed with great care in order to avoid soiling the peritoneum. I usually put in a preliminary purse-string suture and make a knife puncture within the area surrounded by the suture, selecting some coil of intestine which may be drawn outside of the abdomen. The patient is held upon his side and the fluid runs directly out of the intestine into the pus basin. Having emptied as much as possible of the intestine in this way by carefully milking the fluid toward the opening, the suture may be tied, closing the aperture. This procedure may be repeated at two or three points if necessary. The danger in evisceration of the heavy distended gut is injury to the mesentery. Having evacuated the intestine to a safe degree, careful but rapid search may be made for the obstruction, and now the best judgment of the surgeon must come into play in determining whether to treat the case radically or to make a temporary enterostomy or colostomy.

The latter procedure should be reserved for the most desperate cases only.

A method has recently been described by J. W. Elliott (*Annals of Surgery,* November, 1905) which seems to combine the advantages of the radical procedure with those of temporary enterostomy. He draws the affected loop through the abdominal wound, sutures it to the parietal peritoneum, packs gauze into the wound and then ablates the diseased part, suturing together merely the mesenteric attachments of the two legs of the loop to make subsequent anastomosis easier. The patient is then put to bed and in a few days—in fact, during convalescence—the anastomosis is completed. In the cases of obstruction by inoperable growths, side to side anastomosis of distended with collapsed intestine may be of great value.

Department of General Medicine.

In Charge of Dr. E. M. Dupaquier, New Orleans.

Dysentery in Infancy and Childhood.—No bismuth, no rhatany, no tannin, no antipyrin, no opium. The latter, exceptionally, and at the onset, just for severe pain.

Use laxatives (elimination, drainage). Calomel, valuable in cholera infantum, is not so here. Salines are for cases of some standing. On the contrary, castor oil, alone, or with fresh sweet oil, or, preferably, the potion huileuse (French Codex), namely, fresh sweet almond oil 30 grams, julep 125 grams. But this is not tolerated long enough, since this form of enteritis lasts on an average of three weeks.

Therefore, if the attack be not over at the end of a few days, embarrassment begins. Here is a way out of it. Give powdered ipecac (the mainstay if not the specific in dysentery) and a small quantity of sodium and magnesium sulfate. If there be fever, use aconit, dispensing with it as soon as the temperature ceases.

Failing, try a cold maceration of freshly powdered Guarana, 50 centigrams to 1 gram in sweetened water, 120 to 150 *c. c.*, to be given in tablespoonful doses every two hours, day and night. Beware that no simple Paullinia powder is substituted for the complex powder obtained by scraping the roll of Guarana paste. Ask for the pharmaceutical preparation known as paste of dry Guarana powder.

Rectal enemata, the simple cleansing lavage, as well as the medicated ones, viz., peroxid, nitrate of silver, iodin, etc., solutions, should be resorted to with great caution and only when the treatment by mouth fails, since they often increase tenesmus.

No food, water diet, and, next, vegetable decoction (*bouillon de légumes*). [See the February issue of this JOURNAL].

During convalescence the cuisine for babies is still more important. Here are suggestions for those who are not familiar with it.

Resume milk carefully, dilute it with malt coffee (parched barley), then give milk with egg, the thin soups and purées (light paps).

To prevent constipation following the attack, give rhubarb, which is, indeed, the aperient and cholagogue of infants and children.

(Pédiâtrie Pratique—Rousseau Saint-Phillipe—*Gazette des Hopitaux,* Feb. 15, 1906.)

CARBOHYDRATES IN DIABETES.—The amount of carbohydrates permitted is best considered in terms of wheat bread; and most patients prefer to take the amount of carbohydrates permitted them in the form of good wheat bread. Some, however, would rather have it as flour-cakes, and there is no objection to their having it in the form of any simple carbohydrate that they prefer. If the patients take their carbohydrate partly as wheat bread and partly in some other way, then we must subtract the latter amount from the total that is permissible. Suppose, for instance, that the patient is allowed 100 grams of wheat bread—about 60 grams of oatmeal as equivalent to wheat bread, and, therefore, we form, for instance, as oatmeal or rice, in soup, 10 grams being sufficient to make a large dish of a quarter of a litre; or he takes balls of oatmeal, or 25 grams of oatmeal alone. Oatmeal and rice contain about 75 per cent. of starch. We can consider the 10 grams of oatmeal as equivalent to wheat bread, and therefore, we must subtract 10 grams (or to be quite accurate 12 grams) from the daily allowance (100 grams) of wheat bread. Twenty-five grams of grits or rice are equal to about 30 grams of wheat bread. Of course, the patient may have other forms of bread instead of wheat bread. Rolls are useful for this purpose, the amount of starch being almost the same as in wheat bread. The rolls may be cut in small slices and spread with butter. Rye bread is also serviceable; it contains 15 per cent. less of starch, but is heavier and more compact. Aleuronat bread contains only about one-half as much starch as wheat bread, but there are few diabetics who like this bread, although among all the varieties of so-called "diabetic bread" this has the most agreeable taste. (Diabetes mellitus. Practical therapy. Modern Clinical Medicine. Cabot-Salinger. 1906.)

CESTODES OR TAPEWORMS (HISTORICAL).—The larger forms, at least, of tapeworms, were known to the ancients as animal parasites infesting the alimentary canal. The correct notion of the origin and development of a tapeworm is, however, comparatively recent, and for a long time the young worm was supposed to start from the proglottids of the adult worm. The larval forms, or bladder-worms, have also been known, but were regarded as simple cystic tumors, until, almost simultaneously, Redi in Italy, and Hartmann and Wepfer in Germany, inferred their animal nature, after which they were regarded as worms and made by Zeder, in 1800, a separate class, bladder-worms. In 1683 Edward Tyson discovered the head with its double row of hooklets in a large tapeworm in a dog; in 1684 Redi recognized the head and suckers of several forms; in 1700 Andry recognized the head of the Tænia Saginata; and in 1777 Bonnet, and in 1778 Gleichen-Russworm that of dibotriocephalus latus. From that time it was believed that a tapeworm was an animal which nourished itself by fastening its head into the intestinal wall. About the middle of the last century Kuchenmeister, by his celebrated feeding experiments, proved that the cysticerci, or bladder-worms, represented a larval stage in the development of the tapeworm, the latter having for its habitat the intestine of man (in case of those species infesting the human intestine), and the former the muscles and solid organs of certain lower animals, and rarely of man. (Dr. Allen J. Smith. Section on Animal Parasites, Tyson's Practice of Medicine. Fourth Edition. 1906.)

Department of Therapeutics and Pharmacology.

In Charge of DR. J. A. STORCK and DR. J. T. HALSEY, New Orleans.

DIGALEN (DIGITOXINUM SOLUBILIS), A NEW DIGITALIS PREPARATION.—Invaluable and indispensable as is digitalis in the practice of medicine, the usefulness of all of the usual preparations of this drug has been seriously lessened by various undesirable properties. As is well known to every practical medical man, the galenic preparations are of uncertain strength, moreover they, and also the most powerful of the glucosides, digitoxin, are slow and uncertain in their rate of absorption, cumulative in action, often extremely irritant to the alimentary mucous membranes, and always very irritating when given hypodermically. A great desideratum is a digitalis preparation of known strength which acts promptly and which is free, or nearly free, from local irritating effects. According to numerous reports of competent observers digalen comes near to being this desirable and desired digitalis preparation. Among those who have tried digalen extensively and who report most satisfactory results, are Naunyn, Eulenberg, Umber, Kottman. They find this preparation one promptly absorbed, of certain strength, non-cumulative, and, by mouth, non-irritating to alimentary canal. Subcutaneously used it occasionally caused marked irritation, more often slight soreness, or none at all. All the reporters found it far less irritant than the tincture or other preparations of digitalis. The dose is 1 cubic mentimeter (m xv), containing 0.3 mg. of the glucoside, three or four times daily for use by mouth or subcutaneously. The therapeutic effect was obtained in less than 24 hours, often in cases where other digitalis preparations had been tried and had failed..

*Kottman advises the intravenous administration in cases where prompt action is essential and his results are prompt and certainly very striking, the therapeutic action having been manifest within one or two hours. It is remarkable that, to secure any results by intravenous administration, 10 c.c. (3.0 mg.) must be given doses much larger than those usual when given by mouth.

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*Kottman Claims priority in use of digitalis intravenously in human beings but the reviewer knows through personal communication of its having been used in this manner, by Cushing and Dock of Ann Arbor, more than two years ago.

The effects of one intravenous dose last for twenty-four hours or more and are often evident in less than one hour after administration.

The price of the drug is high, a single ordinary dose costing about ten cents and an intravenous one ten times as much, but fortunately in the majority of our cases our galenic preparations work satisfactorily and there will be only occasional and temporary need of using this preparation.

TREATMENT BY DOYEN'S SERUM.—Twenty-six cases were reported to the Societé de Chirurgie by Doyen and Delbet (*Revue de Chirurgie,* No. 9). Most were cancers of the breast. One case remained without recurrence, two were stationary, twenty grew rapidly worse, and three were lost sight of. The report as well as the discussion, in which five other cases are reported with no good results, is entirely unfavorable to its use.—*Therapeutic Gazette*, Dec. 15, 1905.

THE PRIMARY EFFECT OF X-RAYS ON THE TISSUES.—A series of experiments were made by Schultz and Hoffmann (*Deutsche Zeitschrift für Chirurgie, Bd. lxxix, Heft* 4) to determine whether the degenerative changes in glands were due to changes in the blood-vessels and interference with nutrition, or to a direct effect on the epithelial cells. The kidneys of guinea-pigs were dislocated outside the body-wall and exposed directly to the rays. They decided that the primary change was a degeneration and destruction of epithelial cells, and that the increase of connective tissue was secondary . The blood-vessels and glomeruli were not affected, although the lesions resembled interstitial nephritis.—*Ibid.*

ANESTHESIN.—Lotheissen recommends this anesthetic powder for local anesthetic use. Combined with lanolin and vaselin (anesthesin 10 parts, lanolin 50 parts, vaselin 50 parts) it can be used as an anæsthetic lubricant on instruments introduced into the rectum and esophagus, or an anesthetic in the treatment of painful ulcers and fissure in ano.—*Progressive Medicine,* Dec. 1, 1905.

THE MEDICAL TREATMENT OF GASTRIC ULCER AND HYPERCHLORHYDRIA.--Shattuck has contributed to the *Boston Medical and Surgical Journal* of September 21, 1905, an article on this subject which is of unusual interest. In speaking of the hyperchlorhydria associated with gastric ulcer he asserts that there are few conditions more gratifying than it is to treat. An alkali, only palliative in the more severe and persistent cases, is practically curative in those which are more transitory, relieving the distress Soda mint tablets, the author believes, would be better without the mint, and must be taken by the dozen, save in the mildest degrees. It is therefore better to take plain bicarbonate of soda dissolved in plenty of water.

Magnesia, either in powder form or the so-called milk of magnesia, is excellent if there be constipation. But in the higher degrees of hyperchlorhydria the large quantity of magnesia required as an antacid is apt to act too freely on the bowels.

The diet should largely exclude salt, the source of hyperchlorhydria. Condiments should be absolutely excluded. Milk, pure or in combination, or prepared in various ways, is practically always admissible, or even desirable, and the author often allowed soft-boiled, dropped or scrambled eggs, unless experience forbade. Meat, and even fish, are to be temporarily excluded, say for a few weeks, and then permitted only sparingly and tentatively. Diet and such mode of life as tends to restore a more or less tired nervous system, which is apt to be a curative factor, will generally work a cure without the aid of medicine. In severe cases, from one-half to two teaspoonfuls of subnitrate of bismuth before meals seems of distinct benefit, probably acting as a protective coating to the gastric mucous membrane against the food, and thus diminishing the activity and secretion of the peptic glands. In these large doses the drug is not constipating. The microscope shows that the drug has a crystalline formation, which may account for its failure to constipate.

In cases where there is doubt as to whether hyperchlorhydria is complicated by ulcer the above treatment is applicable, save perhaps that the diet may be made more rigid; and this is true also of cases in which ulcer is probable, but in which bleeding has never occurred, or, at all events, has not been recent.

In these cases presenting marked and characteristic ulcer pain, or coming under treatment just after hemorrhage, it is desirable to give the stomach a rest for several days. Morphin is to be given hypodermically in such doses as may be required to allay pain. It may also be given in smaller and repeated doses by the mouth either for restlessness or to blunt an appetite which it is not then safe to indulge. The drug also quiets peristalsis and diminishes glandular secretions.

After three or four days of exclusive rectal feeding, milk and lime-water, a drachm every fifteen minutes can be given by the stomach with daily increase in the amount, lengthening of the interval, or both. In ten to fourteen days, milk toast, junket, rice with cream and sugar, baked potatoes, macaroni, blancmange, and the like, may be added, and rectal feeding omitted. The author believes that in these cases abstinence from meat should be prolonged for at least three months. Food containing starchy things, such as unstrained oatmeal, seed fruits, and the like, are also to be excluded lest they irritate the raw surface. The principle is simply to select such food as demands the least stomach digestion and to avoid irritation as far as may be. Bismuth is desirable until full and ordinary diet has been resumed, say for three to six months. It here serves a double purpose, diminishing secretion and also mechanically protecting the raw surface from both food and such gastric juice as is formed.—*Ibid.*—STORCK.

Department of Ophthalmology.

In Charge of DRS. BRUNS and ROBIN, New Orleans.

NOTES.—In *The Ophthalmoscope* for April 1, 1906, Elmore Brewerton, F. R. C. S., again urges extirpation of the lachrymal sac as the pleasantest and surest remedy for chronic lachrymal sac and duct disease. The operation of dissecting out the sac is difficult and can be best performed, probably, by first injecting the sac with paraffin with a melting point of 110° F. Kuhnt's incision along the anterior lachrymal crest, beginning about 4 mm. above the internal palpebral ligament and passing downwards for about 20 to

25 mm., along the margin of the orbit, is the one favored by Brewerton.

In a Symposium Upon Cataract Extraction, Pagenstecher, of Wiesbaden, publishes a series of aphorisms from which the following may be abstracted: Never operate upon a patient who manifests signs of fever, or whose other eye shows traces of inflammation. If the second eye is phthisical or painful on pressure, enucleate it or rest the optic nerves. Operate only upon mature cataract, and in other cases mature by massage through the cornea, after preliminary iridectomy. A conjunctival flap should be made, and iridectomy should almost always form part of the operation for extraction. Rapid reconstitution of the anterior chamber is the best safeguard against prolapse of the iris, and that is the main reason why Pagenstecher recommends a conjunctival flap. Although the simple operation has many advantages, yet it also has its drawbacks in the shape of prolapse of the iris (8% to 10%), even in the hands of the best operators, inflammatory accidents, sympathetic ophthalmitis, and difficulty in removing cortical masses. This leads Pagenstecher to advise beginners always to practice iridectomy as part of the operation for extraction. Lavage of the anterior chamber should be avoided. Discission through the selero-corneal region should be done when there no longer exists any inflammatory reaction, but as soon as possible. As regards dressing, Pagenstecher employs compresses of gauze, impregnated with a mixture of ichthyol and liquid paraffin, and fixed in place by wool and a metallic framework.—*The Opthalmoscope,* March, 1906.

Department of Ear, Nose aud Throat.

In Charge of A. W. deRoaldes, M. D., and Gordon King, M. D.,
New Orleans.

Subjective Kakosmia.—A. Killian, in the *Munchener Med. Wochen.,* reports two instructive cases of this interesting phenomenon, in which he was able, after most painstaking search, to finally demonstrate the origin of the odor to be in the naso-pharynx. In both cases the Fossa of Rosenmuller contained a caseous concretion analogous to that commonly found in the crypts of the tonsils in chronic lacunar tonsilitis. These concretions gave off a very fetid odor, which the patients were readily able to identify as that of which they had been conscious for a long time. Removal of the mass afforded quick relief. Such cases emphasize the importance of making a careful search for a material cause of the odor of which these patients complain, and not be too quick to attribute the condition to neurotic origin or perversion of the sense of olfaction.

RELATION OF THE NOSE AND THE GENITO-URINARY ORGANS.—Delie, of Ypres, has recently revived the subject of the reaction of these organs to each other, and calls attention to the frequence of phenomena illustrating the fact. He speaks of the perversions of the sense of smell which often constitute the first symptoms of pregnancy, and has also observed that irritation of the nasal mucosa would, in certain cases, cause the involuntary voidance of urine. In one case of urethral stricture the passage of a bougie was much more difficult when the patient had an attack of coryza; also, he mentions the fact well recognized by rhinologists that ablation of adenoid vegetation in children has cured many cases of nocturnal enuresis.

Among other peculiar instances of the nose and the genital organs recounted by the author, are epistaxis, asthma and sneezing coming on during coitus, rhinorrhœa accompanying pregnancy, hypertrophy of the turbinates causing amenorrhœa and dysmenorrhœa, which latter condition can often be relieved by cauterization of the turbinates. Fliess and Jerusalem have observed that the pains of labor can be calmed by the application of cocaine to the inferior turbinates. Delie remarked that women having nasal obstruction could aid but little the expulsive efforts in labor, and sees in nasal obstruction some casual relation to sterility.

Many other peculiar phenomena are related in this article indicating a physiological or psychical relationship between the nose and the generative organs, the nature of which the author does not explain.—*Revue Hebdom. de Laryngol.*

Orleans Parish Medical Society Notes.

Subscription for San Francisco Doctors.

The following communication, which is self-explanatory, was read at the regular meeting of the Orleans Parish Medical Society held May 12, 1906:

To Secretaries of County Societies:

The enclosed editorial from *The Journal of the American Medical Association* for April 28 calls attention to the fact that the Board of Trustees of the American Medical Association has authorized *The Journal* to open its columns for subscriptions to a fund for the relief of the physicians of San Francisco and other California points. *The Journal* of April 28 also contains a list of the contributions already received as a nucleus for this fund. While *The Journal* will reach a large number of physicians, the attention of many will not be called to this appeal. This circular letter is, therefore, sent to the secretary of every county society in the country, as he is in more direct touch with the local profession than any one else.

It is reported that some five hundred physicians of San Francisco have lost all personal property, clothing, etc., and that books, instruments and office fixtures have been destroyed. Beside the actual loss in property, they are also deprived of their means of livelihood, are, in fact, destitute and without means of providing themselves with the necessaries of life, much less with the means for doing their professional work. In months to come there will be a diminution, if not a complete obliteration, of the physician's income, as the people will in many cases be unable to pay physicians for their services. But, of course, our profession will perform its duty to the public without regard to compensation.

There has never been a time when the members of our profession were so greatly in need of prompt and effective aid from their fellows as now, and, no doubt, every physician, who is able to do so, will gladly contribute to a fund for the relief of their California confrères. Will you take up this matter with the officials and members of your society, and, if it meets with approval, bring the matter to the attention of each physician in the county by a personal letter, postal card, or by other means?

Those desiring to contribute to the American Medical Association fund may send checks to the American Medical Association, 103 Dearborn Avenue, Chicago. Endorse checks "California Fund," and make them payable to the American Medical Association. Mark the envelope in which such contributions are forwarded, "California Fund," in the lower left-hand corner. Contributions received will be acknowledged in *The Journal of the American Medical Association,* each contributor's name appearing, no matter how small the contribution.

The undersigned have been selected to act for the Association as a local committee to superintend the receiving and the control of the fund. This committee has asked the Medical Society of the State of California and the San Francisco County Medical Society to appoint a committee, in which all the contributors will have confidence, to superintend the distribution of the fund so that the object for which it is created can be best realized. It is understood that the fund will be distributed to all reputable physicians needing aid, without regard to school of practice.

FRANK BILLINGS, Chairman,
M. L. HARRIS,
CHARLES S. BACON,
ROBERT B. PREBLE,
GEORGE H. SIMMONS,
Committee Representing the American Medical Association.

The following resolution was unanimously adopted:

That the Chair appoint a committee to receive contributions from members of the Society, and that notification of this motion be sent to the members, and, furthermore, that the circular letter from the American Medical Association be published in the official organ of the Society.

The Chair has appointed the following as members of this committee: Dr. J. A. Danna, Chairman; Drs. R. W. Salter and S. P. Delaup.

Medical News Items.

COMMENCEMENT EXERCISES OF TULANE UNIVERSARY.—The Medical Department of Tulane University held its annual commencement exercises on Wednesday, May 2, 1906, at the Tulane Theatre. The Dean, Prof. S. E. Chaille, M. D., delivered an interesting address which is published elsewhere in this number of the JOURNAL. Dr. J. H. White, of the Public Health and Marine Hospital Service, addressed the graduates in a running talk on the obligation of the young medical man to questions of sanitation, touching on the accomplishments of individuals in this regard during the history of medicine. The diplomas were distributed by Dr. E. B. Craighead, the President of Tulane University, who conferred the degrees. The musical program was spread through the commencement and a large audience witnessed the graduation exercises. There were 101 graduates in medicine and 17 graduates in pharmacy.

THE TEXAS STATE MEDICAL ASSOCIATION MEETING was held at Fort Worth on April 24, 25 and 26, and accomplished a most interesting program and successful meeting. Dr. Oscar Dowling, of Shreveport, and Dr. E. D. Fenner, of New Orleans, attended this meeting. The following officers were elected for the coming year: President, Dr. G. B. Foscue, of Waco; Vice-Presidents, Drs. F. P. Miller, S. Wier and A. B. Small; Secretary, Dr. I. C. Chase; Treasurer, Dr. R. F. Miller; the latter two being re-elections. Mineral Wells was selected as the place for the next meeting.

THE NEW ORLEANS COLLEGE OF PHARMACY HELD ITS GRADUATING EXERCISES on the evening of Monday, May 14, at the Tulane Theater before a large audience. The graduates were: Messrs. S. W. Hills, L. P. Blanchard, C. A. Desporte, Jr., R. H. Chargrois, R. H. Rawlings, H. J. Lagarde, Y. V. Terrebonne, L. W. Holmes, J. F. Whitney, E. J. Naquin, J. O. Ferrier, P. F. Dastugue, J. J. Dubourg, J. G. Hirsch, W. J. Gagnet, and Miss Alice Louapre. Dr. Philip Asher read his report as Dean, showing excellent progress in the school during its short life. The degrees were conferred by President George D. Feldner, and the annual address was delivered by Dr. Charles Chassaignac, who dealt with the patent medicine evil.

Meeting of the State Board of Medical Examiners.—The State Board of Medical Examiners met May 3 and 4 and examined 121 candidates for the practice of medicine. There were 105 white candidates successful and nine negroes as follows: L. A. Marks, L. A. Martin, L. C. Heintz, J. E. Pollock, K. T. Klein, D. A. Pettit, E. C. Robichaux, L. L. Whitley, F. V. Gremillion, A. V. Cross, S. S. Hatch, G. S. Gardiner, E. E. Gilbeaux, H. D. King, T. S. Thedford, E. S. Scharff, J. J. Bennett, L. Q. Graves, H. R. Hays, R. J. Mainegra, O. F. Matthews, J. W. Wilson, R. L. Selph, E. W. Smith, G. J. Smith, L. L. Collins, D. Dodge, M. T. Lanaux, W. H. Pipes, J. M. Bodenheimer, W. D. Lester, E. S. Keitz, G. K. Pratt, Jr., S. T. Sherman, C. J. Perot, R. Butler, J. P. Durham, R. T. Perkins, W. T. Polk, A. E. Fisher, E. M. Campbell, J. O. Weilbaecher, W. T. White, E. R. Harrington, L. M. Joiner, C. N. Hoeflich, B. G. Wilbert, J. D. Thompson, T. S. Jones, L. F. Robinson, W. W. Cox, W. S. Martin, F. B. Waits, J. N. Kirk, C. Reed, Adolph Henriques, Henry Weston, S. W. Laub, J. Clifton, W. W. Watson, W. E. Sistrunk, Jr., R. G. Holcombe, C. P. Holderith, A. Mohler, J. W. Moody, M. P. Boebinger, J. J. Mymer, E. E. Ferguson, R. H. Hanchley, W. W. Kitchen, W. E. Burt, W. H. Block, J. E. Brooks, F. O. Maxwell, J. F. Booth, G. C. Lyon, W. P. Prudhomme, T. S. Norwood, C. H. Bradley, R. S. Seagle, B. W. Inman, Jr., J. J. Frater, D. S. Calhoun, W. P. Richardson, H. F. Ader, V. E. Dudley, A. C. McLamore, E. A. Carlyle, W. W. Burdet, D. A. Mann, J. Bath, W. F. Tomson, G. Wallace, E. Desmond, J. W. Huffman, W. C. Middleton, J. S. Adams, W. B. Chamberlin, B. U. Simms, C. M. Petty, L. M. Thomason, J. P. Lokey, L. R. Young, J. A. Pipkin, J. A. Minton.

The colored applicants who passed the examinations were: W. D. Wilson, F. T. Jones, J. D. Nelson, W. Wallace, I. J. Washington, W. Gozey, W. E. Shalarone, T. Taylor and A. H. Johnson.

For certificates as midwives there were ten applicants. One white woman and six negro women passed the examination. These were: White, Mrs. W. Ray, 2124 Terpsichore; colored, Mary

Huddleston, 1017 S. Robertson; G. Dumoil, Baton Rouge, La.; O. Gould, 1917 First street; Betty Collins, Baton Rouge, La.; Louise Fournet, 2004 Howard avenue; Pauline Alexander, 2135 St. Andrew.

The next examination by the State Board of Medical Examiners will be held Oct. 18 and 19, of the present year. The members of the Board are: Dr. A. F. Barrow, of St. Francisville; Dr. F. M. Thornhill, Arcadia; Dr. F. A. Larue, New Orleans; Dr. E. L. McGehee, New Orleans; Dr. C. D. Simmons, Baton Rouge.

VIOLATION OF PHARMACY LAW.—The Louisiana Pharmaceutical Association instituted proceedings against John F. Krumpfer, a druggist in New Orleans, on the ground of violating the State Pharmacy Law by compounding drugs without a license. The Association proposes the prosecuting of all such infringements, and will also attack the practice of selling poisonous drugs.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION.—The American Medical Association meets at Boston on June 5, 6, 7 and 8. The house of delegates will convene at Boston Medical Library at 10 a. m. on Monday, June 4, 1906. The May 5 number of the Journal of A. M. A. gives detailed advices regarding sections, hotels, entertainments, etc.

THE AMERICAN PROCTOLOGIC SOCIETY will hold its eighth annual meeting in Boston, Mass., June 5 and 6, at the Hotel Vendome. An interesting program has been arranged and the profession is invited to attend all sessions.

PERSONALS: Dr. Warren S. Bickman, of New York, attended the meeting of the State Medical Society and was entertained by Drs. L. G. LeBeuf and F. W. Parham.

Dr. Eugene Walet was elected President of the Charity Hospital Alumni Association on May 7.

Dr. C. V. Unsworth has returned from Texas, where he was called professionally.

Dr. Charles Faget has returned from San Francisco, where he spent some time recently.

Dr. N. J. Milstead has left Waverly, La., and will practice at Jackson, Miss. The doctor will give up general work and devote his time to special work.

Dr. H. W. Jarrell has changed his location from Aycock to Arcadia, La.

Dr. C. M. McCain has moved from St. Maurice, La., to Winnfield.

Dr. Edith Loeber, of New Orleans, gave a talk to the Normal School students about "Health in Schools."

Dr. John W. Ross, U. S. N., spent a few days in New Orleans during and after the Confederate reunion.

Dr. T. A. Miller, of Corsicana, Texas, who was the first doctor to matriculate at the New Orleans Polyclinic when it began in 1888, attended the present session of that institution. The surviving members of the original faculty were very glad to greet Dr. Miller and he was highly pleased at the evidence of improvement and prosperity shown by the Polyclinic.

THE MISSISSIPPI MEDICAL JOURNAL has again changed its name and is now known as the *Mississippi Medical Monthly.*

DIED: Dr. C. W. Hilton, a valued friend of the JOURNAL, died last month at Monroe, La., aged 45 years. The doctor was a graduate of Tulane in 1887 and was a member of the State Medical Society and of the American Medical Association.

The Louisiana State Medical Society Meeting.

The twenty-seventh annual meeting of the Louisiana State Medical Society convened Tuesday morning, May 8, at 9:30, with the President, DR. C. J. DUCOTE, in the chair. The RIGHT REV. DAVID SESSUMS delivered the invocation and was followed by DR. C. JEFF MILLER, President of the Orleans Parish Medical Society, who welcomed the State body to New Orleans and assured them of the cordial hospitality of the local profession. The President read his annual report, showing an increase in membership of 38, making a total of 900, with 48 out of 59 parishes organized into local societies. The report also touched upon general matters of medical history during the year, and especially of the work accomplished during the yellow fever experience. The Secretary, Dr. P. L. Thibaut, read his report, which was well received. Dr. E. J. Graner, of New Orleans, Chairman of the Council, reported 1,884 registered physicians in the State. He dwelt upon the importance of medical representation on the Board of Administration of Tulane University and referred to the work done for the Medical Practice Act. A compliment was paid the membership on prompt replies to the several communications which were issued from his office.

Dr. F. W. Dortch presented a set of resolutions directed at the consideration of legislation regulating the sale of patent and proprietary medicines. This was referred to a committee to be appointed by the President for a report as to the action of the Society at a later session of the meeting.

The afternoon session was occupied by the scientific section, that on General Medicine being the order of the day. Papers were read by Dr. F. M. Thornhill, on "Typhoid Fever"; Dr. Joseph Atkinson, on "Anomalies of Typhoid Fever"; Dr. A. B. Nelson, on "Diagnosis and Medical Treatment of Gall-Stones"; Dr. A. E. Fossier, on "Raynaud's Disease," all of which were fully discussed. (As all papers are to be published in full, with their complete discussion, only running mention will be made at this time.)

At the conclusion of the morning session a buffet luncheon was served at the New Orleans Polyclinic.

The night session was devoted to a Symposium on the Sanitary Control of Yellow Fever. The subject was introduced by Dr. F. J. Mayer, of Scott, La., who reviewed the experiences of 1905 and, additionally, covered certain points regarding the habits of the mosquito and possibility of remote infection through transportation of these.

Dr. John Callan, of Orleans, dwelt on the mosquito theory and emphasized the necessity of constant effort against this menace. Dr. B. O. LeBlanc, of St. Gabriel, referred to the method of surrounding the house with mosquito net when fumigation was practiced in order to catch escaping mosquitoes.

Dr. James Carroll, of Washington, and of the U. S. Army, whose notable work in connection with yellow fever in Cuba is so well known, followed with a discussion of the Louisiana epidemic of last year. The salient features of his paper were a review of the work done in the study of the mosquito in its relation to yellow fever; the history of epidemics in New Orleans and their relation to outbreaks in smaller places; the early suggestions with regard to the relation of insects and yellow fever, in which the work of Dr. Josiah C. Knott, of Mobile, was fully credited. He also discussed restrictions upon vessels from infected ports. The essayist concluded with recommendations for international co-operation dealing with each of the phases considered in the prevention of this disease. Among those who discussed the question were Drs. H. D. Bruns, Q. Kohnke, C. M. Brady and H. P. Jones.

Dr. S. D. Gustine, of Kenner, read a paper on "How the Yellow Fever Was Handled in Kenner in 1905." Aside from the interest in the experiences related the doctor's conclusions were that sanitation and hospital treatment were points of moment.

A similar paper, dealing with sanitary work in his district, was read by Dr. R. F. Bernard, of Lake Providence. Dr. Sidney L. Theard, of Orleans, delivered a most interesting and logical paper on "Requirements of Maritime and Inland Sanitation in the Line of the Mosquito Doctrine." While dealing strictly with the question as indicated by the title a thorough treatment of the handling of mosquitoes in domiciles was reviewed.

There followed papers by Dr. G. F. Patton, of Orleans, on the "Differential Diagnosis Between Dengue and Yellow Fever," and by Dr. L. Sexton, of Orleans, on "Some of the Difficulties in Diagnosing Yellow Fever."

The meeting adjourned at a late hour.

The second day of the meeting was characterized by a number of papers of a high class of excellence. The morning session was opened by Dr. Warren Stone Bickham, now of New York, but formerly of New Orleans. Dr. Bickham came as an invited guest of the Society and read an academic paper on the "Operative Surgery of the Spine and Cord." At the conclusion of his paper a demonstration of the technic described was made. The essayist received the closest attention and the discussion which followed indicated the importance of his contribution to surgery. Among those who discussed the paper were DRS. MATAS, PARHAM, GESSNER, FENNER, VAN WART, BLOOM, MARTIN, W. M. PERKINS and P. E. ARCHINARD. At the conclusion a vote of thanks was unanimously tendered Dr. Bickham by the Society.

DR. H. D. BRUNS, of Orleans, presented a paper on "What Every Physician Should Know About Ophthalmology." The paper dealt with the simpler affections of the eye which fall under the notice of the general practitioner, and which he should be prepared to treat. Practical remedies were suggested and methods of application related. The reader inveighed against the popular practice of patronizing unqualified itinerant eye doctors and shops for the adjustment of glasses.

The paper on "Blood Pressure in Yellow Fever," by DR. J. BIRNEY GUTHRIE, of Orleans, attracted considerable attention and showed a large degree of research.

DR. L. G. LEBEUF, of Orleans, read on "Diet and Handling of the Newborn," in which a plea for the use of goat's milk was made as safe diet for infants.

DR. E. D. FENNER, of Orleans, read a paper on "The Surgical Phases of Spina-bifida."

DR. AMEDEE GRANGER, of Orleans, read an excellent paper on the "Importance of the Knowledge of Electro-Therapeutics," and indicated its practical usefulness to the regular practitioner. The paper was comprehensively presented and was appreciated by the audience. The discussion by DR. N. F. THIBERGE brought out the relation of the use of the X-Ray in severe neuralgias of the larger trunks, and also was marked by the presentation by Dr. Thiberge of radiographs showing the practical usefulness of specula tubes for limiting and concentrating X-Ray applications.

Several papers of interesting title were referred to the Publication Committee owing to the length of the program and lack of time to take up all of these.

A resolution of DR. O. M. PATTERSON, of Morehouse, introduced the preceding day, was voted on and lost by a large majority. It proposed to amend the By-laws so as to revert to the old time formation of a Nominating Committee by the selection of one delegate from each parish society.

At twelve o'clock a recess was taken for the formation of a Nominating Committee with the following result: From the First Congressional District, Drs. H. Dupuy and W. H. Robin; Second Congressional District, Drs. Charles Chassaignac and Wm. M. Perkins; Third Congressional District, Drs. J. J. Ayo and C. J. Edwards; Fourth Congressional District, Drs. Oscar Dowling and A. B. Nelson; Fifth Congressional District, Drs. O. M. Patterson and C. L. Remage; Sixth Congressional District, Drs. J. A. Carruthers and A. F. Barrow; Seventh Congressional District, Drs. W. R. Boudreaux and J. L. Watson.

After the morning session the Society adjourned to the laboratory of the Tulane Medical Department, where the faculty entertained at a most enjoyable lunch.

The night session of the second day was devoted to the President's address, the annual oration and a special paper directed at the control of epidemics.

The session of the meeting devoted to the President's address is always open to the public and, as usual, a large audience, comprising a number of ladies, was present.

DR. C. J. DUCOTE, President of the Society, selected as his topic the "Life and Work of Dr. Walter Reed," a timely and worthy subject for the occasion. The biography of Dr. Reed was related, together with his service to the history of medicine, and particularly to that part in which New Orleans and other yellow fever sufferers were especially connected. Attention was called to the proposed monument in his memory at Washington, and a beautiful tribute was paid when his martyrdom to yellow fever was dwelt upon.

Following the President's address MR. HENRY P. DART, of the New Orleans Bar, delivered the annual oration. Mr. Dart, in a lucid, comprehensive and logical address, considered the constitutionality of the proposed Federal control of quarantine. The address reviewed the history of the relation of the United States Government to matters of quarantine and showed the gradual development of a national interest in the conditions which existed in the several States concerned. The keynote of the argument was based upon the decision of Chief Justice Marshall, who was quoted to the effect that "there can be no question as to the right of the Government to regulate the movement of men and matter during the time of the existence of epidemics or contagious diseases, as much so as in case of war."

Dr. W. H. Sanders, of Mobile, followed Mr. Dart with a paper on "Co-operation Among Southern States for the Prevention and Control of Epidemics." He opposed Federal control mostly on the ground that the medium of such control in the hands of the Public Health and Marine Hospital Service was too autocratic. He believed that an understanding aiming at consistent co-operation was very much more desirable and if rightly undertaken should result in effective measures.

The third day began at the usual hour with the President, as always consistently, in the chair.

The session opened with the Report of the Nominating Committee, which was unanimously adopted. The report named the following officers: For *President,* Dr. H. Dickson Bruns, of Orleans; *First Vice-President,* Dr. Chas. McVea, of East Baton Rouge; *Second Vice-President,* Dr. George F. Wilson, of Bienville; *Third Vice-President,* Dr. A. J. Perkins, of Calcasieu; *Secretary,* Dr. P. L. Thibaut, of Orleans; *Treasurer,* Dr. Jules Lazard, of Orleans.

Councillors: First District, Dr. P. E. Archinard, of Orleans; Second District, Dr. E. J. Graner, of Orleans; Third District, Dr. J. W. Sanders, of Iberia.

To fill vacancies on Board of State Medical Examiners: Dr. F. M. Thornhill, of Bienville, and Dr. J. C. Willis, of Caddo.

The Committee appointed by the President to report on the action of the Society regarding legislation in the matter of patent and proprietary medicines reported in substance that the question was one which required a thorough preparation and that it should be laid over for another session of the Society in order that the action of other States should be reviewed and that the Society might be ready and prepared to go before the next Legislature. The matter was referred to a special committee.

The regular program was, on motion, postponed to allow Dr. Sidney L. Theard to read a paper on the "History of Yellow Fever in 1905." This paper dealt specifically with the point that the officers of the local Board of Health had broken the backbone of the fever before the Marine Hospital Service assumed charge.

The morning session was occupied with interesting papers, among which was that of MR. J. C. SMITH, a guest of the Society, which attracted unusual attention. He read on "Recent Observations on the Life Habits of the Stegomyia." Notable points were that this pest will breed in salt water, and that the eggs of the mosquito survived the cold weather. A vote of thanks followed the reading of the paper and in appreciation of its merits Mr. Smith was elected an honorary member of the State Medical Society.

Among other papers read were the following: DR. W. M. PERKINS, on "The Surgical Use of Iodin"; DR. A. NELKEN, on "The Venereal Peril and Public Apathy"; DR. F. W. PARHAM, on "Exstrophy of the Bladder," which attracted attention because of the evidence of technic and of skillful surgery displayed. The discussion of Dr. Parham's paper evoked complimentary remarks and urged the younger element of the surgical division of the local profession to follow so illustrious an example.

DR. HOMER DUPUY read on "Laryngeal Tuberculosis"; DR. J. F. BUQUOI, on "Pruritis and Its Treatment."

Several resolutions were introduced at the conclusion of the day's meeting extending the thanks of the Society to the local profession, the press, Tulane Faculty and New Orleans Polyclinic for various and sundry courtesies. Also resolutions were adopted declaring against reduction in life insurance examination fees and the Society went on record as favoring the declaration of the first cases of yellow fever and as approving the screening of all fever patients.

The meeting concluded with the installation of the incoming officers and finally adjourned to meet in New Orleans on May 14, 15 and 16, 1907.

Nearly 200 members of the State Society gathered on the night of the third day at the Rathskeller at a banquet tendered by the Orleans Parish Medical Society. The tables were beautifully decorated with the season's flowers and the feast was interspersed with delectable music and marked by notable addresses. DR. J. M. MAGRUDER, Chairman of the Committee of Arrangements, presided as toastmaster and introduced a variety of speakers, each of whom delivered himself fitly.

Among those who spoke were DR. C. JEFF MILLER, who responded to the toast of the Orleans Parish Medical Society, briefly pointing to the growth of the local Society and the earnestness of its work, and concluding with a spirit of welcome to the guests of the New Orleans profession.

DR. C. J. DUCOTE spoke of the State Society during its past year and emphasized the success of the recent gathering. The new President, DR. H. D. BRUNS, spoke on the purposes of the medical profession in their relation to the State Society and to the profession as a whole. His address was full of logical thought, and earned the repeated applause with which it was followed.

DR. J. T. HALSEY responded to the toast to Tulane University and pointedly related its position among the medical colleges in the country, especially dwelling upon the superior advantages which this department already offered and promised for the future.

DR. E. B. CRAIGHEAD, President of the Tulane University, delivered a lengthy address which argued for the usefulness of Tulane as a civilizer, and which carried a plea for the support of every physician in the State of Louisiana to make Tulane representative of the State and of the South. The argument was advanced that nowhere in the South was such an opportunity afforded for the development of a great University, but that Tulane needed the support of every citizen and, incidentally, a large interest on the part of the State Legislature.

There followed speeches by DR. ISADORE DYER, who responded for the Polyclinic; DR. JOSEPH HOLT, who feelingly delivered an appropriate address to the "Young Men of the Profession," urging upon them the great responsibility which rested on them, and euphemistically related in metaphor the purpose of the medical man.

DR. ALBERT MAYER spoke for the "Country Doctor"; DR. A. F. BARROW, to the toast to "The Ladies," and DR. G. A. B. HAYS concluded with a witty reference to the "Far Country of the Alienist."

NOTES OF THE MEETING: The following members of the State Society were registered at the meeting, according to parishes (excepting Orleans):

LOUISIANA STATE MEDICAL SOCIETY.

Registration at 1906 Meeting.

Acadia: Drs. D. D. Mims and M. L. Hoffpauir, Crowley; L. B. Arceneaux, Church Point; R. C. Webb and J. P. Mauboules, Rayne; L. A. Clark, Iota.

Ascension: Dr. E. K. Sims, Donaldsonville.

Assumption: Drs. A. J. Himel, Napoleonville; A. A. Landry, Paincourtville.

Avoyelles: Drs. Henry Buck, Red Fish; W. G. Branch, Bunkie; W. F. Couvillion, S. DeNux and L. C. Tarleton, Marksville; G. L. Drouin and T. A. Roy, Mansura; C. J. Ducoté, Cottonport; Gordon Morgan, Woodside; W. A. Quirk, Evergreen.

Bienville: Drs. F. M. Thornhill, J. Atkinson and A. B. Nelson, Arcadia; G. F. Wilson and O. O. Hamner, Bienville; C. C. Allums, Manning.

Bossier: Dr. J. L. Scales, Alden Bridge.

Bi-Parish Medical Society, composed of Natchitoches and Red River: Drs. W. W. Teer and J. T. Keator, Bermuda; Z. T. Gallion, Natchitoches; C. E. Edgerton, Coushatta; E. W. Breazeale, Campti; P. E. Waddell, Clarence.

Caddo: Drs. I. M. Calloway, Oscar Dowling, T. E. Schumpert and J. A. Selby, Shreveport.

Calcasieu: Drs. C. F. Howell, Kinder; V. A. Miller, Lake Arthur, and A. J. Perkins, Lake Charles; G. W. Remage, Jennings.

Catahoula: Dr. W. E. Pugh, Wildsville.

Concordia: Dr. C. H. Burley, Monterey.

East Baton Rouge: Drs. J. A. Caruthers, C. F. Duchein, Charles McVea, L. E. Morgan and J. A. Tucker, Baton Rouge; J. A. Minton, Baywood; T. C. Foreman, Foreman; W. D. Harelson, Comite.

East Carroll: Dr. F. R. Bernard, Lake Providence.

Feliciana Medical Society, composed of East Feliciana and West Feliciana: Drs. W. F. Hagaman, Norwood; E. M. Hummel, Jackson; H. Johnston, Wilson; A. F. Barrow, St. Francisville; J. M. Daniel, Star Hill.

Franklin: Drs. C. L. Remage, Winnsboro; J. L. Denson, Crowville.

GRANT: Drs. T. J. Harrison and J. L. Woodall, Montgomery; J. V. Bonnette, Pollock; D. W. Kelly, Selma.

IBERIA: Drs. M. B. Tarleton, Jeannerette; J. W. Sanders, New Iberia.

IBERVILLE: Drs. A. A. Allain, Bayou Goula; W. G. Owen, E. A. Pierce and P. B. Landry, White Castle; B. O. LeBlanc, St. Gabriel; W. L. Grace, Plaquemine.

JEFFERSON: Dr. A. D. Gustine, Kenner.

LAFAYETTE: Dr. Fred. J. Mayer, Scott.

LAFOURCHE: Drs. Thomas Stark, A. J. Meyer and J. Albert Price, Thibodaux; J. J. Ayo, Bowie; Gally Wogan, Lafourche Crossing.

LINCOLN: Dr. S. L. White, Ruston.

MOREHOUSE: Dr. O. M. Patterson, Bastrop.

OUACHITA: Drs. M. A. McHenry, R. W. Faulk and J. J. Newton, Monroe.

PLAQUEMINES: Drs. C. Y. Seagle, Belair; G. A. B. Hays, Pineville; H. L. Ballowe, Buras.

POINTE COUPEE: Dr. L. E. Bergeron, Oscar.

RAPIDES: Drs. C. J. Gremillion, R. L. Randolph, J. L. Wilson, G. E. Cannon and R. F. Harrell, Alexandria; E. Lee Henry, Lecompte.

SABINE: Dr. J. B. Parrott, Zwolle.

ST. JAMES: Drs. L. A. Gaudin, B. Winchester and J. F. Buquoi, Convent; L. O. Waguespack, Oubre.

ST. LANDRY: Drs. W. R. Boudreau and L. Lazaro, Washington; R. M. Littell, Opelousas; R. C. Hawkins, Palmetto; T. T. Tarlton, Grand Coteau; J. C. Vidrine, R. S. Dossman and E. Thompson, Ville Platte; H. C. Milburn, Whiteville.

ST. JOHN-ST. CHARLES: Drs. S. Montegut, Laplace; R. D. Wilson, Edgard; V. Lehmann, Hahnville.

ST. MARTIN: Dr. A. Guilbeau, Breaux Bridge.

ST. TAMMANY: Drs. R. B. Paine, Mandeville; G. R. Tolson, N. M. Hebert and J. F. Piggott, Covington; T. J. Dimitry, Madisonville.

TANGIPAHOA: Drs. J. W. Lambert and R. W. Travis, Tangipahoa; E. O. Powers, Grangeville; L. E. Allen, Independence; Russell E. Stone, Amite City; H. G. Morris and J. H. Ellis, Kentwood; A. F. Gates, Hammond; H. H. Gates, Ponchatoula.

TENSAS: Dr. E. F. Newell, St. Joseph.

TERREBONNE: Drs. Leon J. Menville and J. B. Duval, Houma.

UNION: Dr. C. H. Jameson, Farmerville.

VERMILION: Drs. J. T. Abshire, LeRoy; C. J. Edwards, Abbeville.

VERNON: Drs. F. W. Dortch, DeRidder; A. F. O'Connor, Neame; J. D. Tuten, Barham; W. P. Perkins, Leesville.

WASHINGTON: Drs. J. L. Brock, Franklinton; C. G. Coyle, Cotton Valley; W. R. Buffington, Yellow Pine.

WEST BATON ROUGE: Drs. H. Guy Riché, Chamberlin; C. A. Weiss, Lobdell.

WINN: Dr. J. J. Peters, Winnfield.

ORLEANS: There were 204 members registered from the Orleans Parish Medical Society.

GUESTS: Dr. Warren S. Bickham, 448 Madison Avenue, New York, N. Y.; Dr. James Carroll, Washington, D. C.; Dr. W. P. Chamberlain, Captain and Assistant Surgeon U. S. Army, New Orleans.

VISITORS: Dr. Louis D. Dickerson, McComb City, Miss.; Dr. N. H. Grady, Monette, Ark.; Dr. C. C. Hall, Arguilla, Miss.; Dr. Wm. Neville, McComb City, Miss.; Dr. W. D. Patton, Amarillo, Texas; Dr. M. W. Rainold, Pass Christian, Miss.

ASSUMPTION PARISH MEDICAL SOCIETY.—The Assumption Parish Medical Society held its regular quarterly meeting in Paincourtville on April 19. The scientific program consisted of a paper, "The Early Diagnosis of Malignant Tumors," by Dr. Adrian Landry, and discussion. It was unanimously resolved to hold bimonthly meetings hereafter, instead of quarterly. This speaks well for the interest taken in the Society by the profession of the parish. The meeting closed with a luncheon at the residence of Dr. Landry, Secretary of the Society.

Book Reviews and Notices.

All new publications sent to the JOURNAL *will be appreciated and will invariably be promptly acknowledged under the heading of "Publications Received." While it will be the aim of the* JOURNAL *to review as many of the works received as possible, the editors will be guided by the space available and the merit of the respective publications. The acceptance of a book implies no obligation to review.*

Gray's Anatomy; new American edition by JOHN CHALMERS DACOSTA, M. D. Lea Brothers & Co., Philadelphia and New York, 1905.

This is an exhaustive treatise of Gray's Anatomy, edited by Pick & Howden and thoroughly revised and re-edited with additions by the well known Professor of Clinical Surgery in the Jefferson Medical College (Phila.).

It is the latest American edition, appearing nine years after its predecessor. To give an idea of the increased scope of the present volume, there are 1132 elaborate engravings as compared to 772 in the previous edition.

Many books on anatomy, both foreign and American, have been freely consulted and quoted; clear and beautiful illustrations have been borrowed for this present complete work.

In fact, one has but to glance through the different editions of Gray, from the first edition which appeared in 1858 to the last, to realize that this volume of DaCosta is almost entirely new.

LARUE.

Report of the Board of Administrators of the Charity Hospital to the General Assembly, 1905.

In 1905, 9,074 patients were treated in the hospital, and 19,429 in the out-door clinics, with a total consultation of 68,458.

The daily per capita expense for patients was 62 3-5 cents. Including employees, staff, etc., the per capita expense was 45 cents.

The total income of the hospital for 1905 was $170,934.70, including $12,939.24 carried over from previous year. The expenditures amounted to $160,768.57. The chief items were $22,275.60 for employees; $18,474.93 for officers' salaries, together making over one-fourth of the expense; $16,093.98 for medical and surgical supplies; $50,902.43 for domestic supplies, including food. The balance was expended for various and sundry contingencies.

In the hospital itself, the chief improvement was in the equipment of a radiotherapy room. The usual tables of the entry analytically the birth of each department are given. The average mortality rate of the hospital in its 74 years of existence is estimated at 13.1%.

Publications Received.

W. T. Keener & Co., Chicago, 1906.

A Manual of Medical Treatment or Clinical Therapeutics, by Dr. I. Burney Yeo. Vols. I and II.
Materia Medica and Therapeutics, by Dr. J. Mitchell Bruce.

J. B. Lippincott Co., Philadelphia and London, 1906.

International Clinics. Vol. I. 16th Series.

P. Blakiston's Son & Co., Philadelphia, 1906.

Manual of Diseases of the Ear, Nose and Throat, by Dr. John Johnson Kyle. *On Carbogydrate Metabolism,* by Dr. F. W. Pavy.

Year Book Publishers, Chicago, 1906.

Practical Medicine Series. Vol. I. *General Medicine.* Head-Billings-Salisbury.
Practical Medicine Series. Vol. II. *General Surgery.* Head-Murphy.

W. B. Saunders & Co., Philadelphia and London, 1906.

A Treatise on Diagnostic Methods. Sahli-Kinnicutt-Potter.
A Treatise on Surgery, by Dr. George Ryerson Fowler. Vol. I.
A Manual of the Diseases of Infants and Children, by Dr. John Ruhrah.
Reference Handbook of Diseases of Children, by Dr. Ferdinand Fruhwald and Dr. Westcott.
Text-Book of Gynecology. Ashton.

Miscellaneous.

Transactions of the American Rœntgen Ray Society.
Report of the Board of Administrators of the Charity Hospital to the General Assembly of the State of Louisiana, 1905.
Twenty-ninth Annual Report of the Board of Health of the State of New Jersey, 1905.
Infant Feeding. Circular issued by the Illinois State Board of Health.
Fifty-seventh Annual Report of Trustees and Superintendent of the Central Indiana Hospital for the Insane, 1905.
Thirty-second Annual Report of the Medical Director of the Cincinnati Sanitarium, 1905.
Locomotor Ataxia, by Dr. J. F. Langdon.
Program Arkansas Medical Society.
Perjury for Pay, by Dr. Willis P. King. (The Burton Co., Publishers, Kansas City, Mo., 1906.)
The Autotoxiceses, by Dr. Heinrich Stern. (G. P. Engelhard & Co., Chicago, 1906.)

Reprints.

The Localization of the Higher Psychic Functions. Mills-Weisenburg.
Yellow Fever Prophylaxis in New Orleans, 1905, by Prof. Rupert Boyce, *Dean of the Liverpool School of Tropical Medicine.*

MORTUARY REPORT OF NEW ORLEANS.

(Computed from the Monthly Report of the Board of Health of the City of New Orleans.)

FOR APRIL, 1906.

CAUSE.	*White.*	*Colored.*	*Total.*
Typhoid Fever	5	1	6
Intermittent Fever (Malarial Cachexia)	1	2	3
Smallpox	....	....	....
Measles	....	....	....
Scarlet Fever	4	....	4
Whooping Cough	1	....	1
Diphtheria and Croup	2	....	2
Influenza	4	3	7
Cholera Nostras	2	....	2
Pyemia and Septicemia	1	....	1
Tuberculosis	37	36	73
Cancer	10	7	17
Rheumatism and Gout	1	....	1
Diabetes	1	....	1
Alcoholism	1	1	2
Encephalitis and Meningitis	7	1	8
Locomotor Ataxia	....	....	....
Congestion, Hemorrhage and Softening of Brain	18	4	22
Paralysis	4	1	5
Convulsions of Infants	1	2	3
Other Diseases of Infancy	15	5	20
Tetanus	1	5	6
Other Nervous Diseases	....	1	1
Heart Diseases	35	45	80
Bronchitis	3	3	6
Pneumonia and Broncho-Pneumonia	22	22	44
Other Respiratory Diseases	2	6	8
Ulcer of Stomach	....	....	....
Other Diseases of the Stomach	4	....	4
Diarrhea, Dysentery and Enteritis	28	15	43
Hernia, Intestinal Obstruction	4	....	4
Cirrhosis of Liver	7	....	7
Other Diseases of the Liver	2	1	3
Simple Peritonitis	1	1	2
Appendicitis	4	....	4
Bright's Disease	20	17	37
Other Genito-Urinary Diseases	2	4	6
Puerperal Diseases	2	2	4
Senile Debility	12	4	16
Suicide	4	1	5
Injuries	12	11	23
All Other Causes	11	12	23
TOTAL	292	213	505

Still-born Children—White, 20; colored, 24; total, 44.

Population of City (estimated)—White, 245,000; colored, 88,000; total, 333,000.

Death Rate per 1000 per annum for Month—White, 14.34; colored, 29.04; total, 18.16.

METEOROLOGIC SUMMARY. (U. S. Weather Bureau.)

Mean atmospheric pressure	30.09
Mean temperature	69.
Total precipitation	1.08 inches.

Prevailing direction of wind, southeast.

5E.

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